**Your Header**

Name

Practice Name

License Number

Address

Phone Number

Email

**Telehealth Informed Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client's full name), understand that my therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Therapist's full name), is providing psychological services through telehealth.

* **Nature of Telehealth Therapy**: Telehealth therapy involves the delivery of therapeutic services using interactive electronic systems between the therapist and the client when they are not in the same physical location.
* **Benefits and Risks:**
	+ Benefits can include increased accessibility and convenience of therapy. It can also allow for continuity of care if in-person sessions are not feasible.
	+ Risks can include, but are not limited to: disruptions in service due to technical difficulties, potential breaches in confidentiality, and limits to the therapist's ability to respond to emergencies.
* **Confidentiality**: Standard confidentiality protections apply to telehealth services. However, there are unique challenges to maintaining privacy. I will make every effort to find a private location for my sessions and use headphones when needed. My therapist will do the same.
* **Emergencies**: I understand that if I am in crisis or in a situation that requires immediate risk assessment, I should not rely on telehealth. Instead, I will go to the nearest hospital or call emergency services. Please call **911** or the **988** Suicide and Crisis Lifeline.
* **Technology:** It is my responsibility to secure the necessary computer, smartphone, or tablet needed for telehealth services. I understand that the internet connection should be robust enough for video conferencing. If technical problems occur during a session, my therapist and I will end the session and determine an alternative method for communication.
* **Fees and Cancellation:** The same fee rates will apply for telehealth as in-person sessions. I understand that I must give notice (e.g., 24 hours) if I need to cancel a session, or I may be charged a cancellation fee.
* **Recording:** Neither party will record the telehealth sessions unless agreed upon in writing.
* **Client's Location:** I agree to inform my therapist of my location at the start of each session and provide a local emergency contact number.

By signing this document, I acknowledge that I have read, understood, and agree to the terms above. I have had the opportunity to ask questions and have them answered. I hereby give my informed consent for the use of telehealth in my therapeutic sessions with [Therapist's name].

Client's Name (printed) Date

Client's Signature