**INFORMED CONSENT TO TELEHEALTH**

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as “Telehealth”) with my therapist.

I understand I have the following rights under this agreement:

* I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential, outside of the mandatory reporting laws stated within my registration form.
* I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
* I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
* I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. In such circumstances, telephone sessions can be used.
* In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.
* One of the advantages to Telehealth is that it can flexibly provide continuity of care when an in-person treatment session cannot be conducted in the office. Therefore, I understand that similar to a regular in-person therapy session, telehealth allows for both verbal and non-verbal communication.
* Similar to in-person services, if an emergency should occur during a telehealth session, I understand the psychotherapist may consider taking any steps necessary to ensure the safety of the client (myself) or of others.
* Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological service. As such, I understand all other policies and consents in the psychotherapist’s office agreement forms apply to telehealth services. This document is an addendum to, and not a substitute for, Avedian Counseling Center’s standard in- office services agreements.
* I understand that telehealth services are a professional service, and a fee is charged at the same rate as in- person services.
* Even when health insurance covers in-person services, health insurance may limit or deny coverage of telehealth services. I, as the client, am responsible for confirming and knowing in advance what my insurance may or may not cover. If my insurance does not cover telehealth services, I understand that I will not receive the reimbursement.
* I further understand that telehealth sessions are scheduled in advance by prior arrangement. Scheduling a telehealth appointment involves reserving time specifically for myself, the client.
* I understand that cancellations and missed appointments are the same as the previously mentioned policies for in-person sessions.
* I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event, or condition on which this content expires. I have the right to opt in or opt out of the methods of telehealth communication at any time, without affecting my right to future care or treatment.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I hereby authorize Avedian Counseling Center to use HIPAA compliant and secure telemedicine technology for our therapy sessions.

I understand that I can withdraw my consent to Telehealth communications by providing written notification at any time. My signature below indicates that I have read this Agreement and agree to its terms.

# Please select one:

* I DO agree to telehealth sessions
* I do NOT agree to telehealth sessions

# If you do authorize telehealth sessions, please sign below: