Consent for Teletherapy

Client Name: _____ Client ID: _____

Caregiver Name: _____

I, _____, hereby voluntarily consent to engage in teletherapy for myself and/or my child. Teletherapy is a form of therapy provided via internet technology, which can include consultation, treatment, transfer of protected health information, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Limitations on Confidentiality
Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client/legal guardian of client, need to be a resident of Florida.
2. I, the client/legal guardian of client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I signed when beginning therapy with Positive Solutions Therapy.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.
7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for:
    - Providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions.
    - Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
    - It is the responsibility of the psychological treatment provider to do the same on their end.

Duration of Consent
I understand my consent for treatment is freely given and may be withdrawn at any time. In cases of shared parental custody for treatment on a minor, I understand it is the right and responsibility of the custodial parent to advise the non-custodial parent of the child's treatment and the non-custodial parent has the right to withdraw consent at any time.

Legal Guardian (if child is client)

I, _____, do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my legal consent to the treatment and services mentioned in this form.

_____	_____	_____
Printed Name of Client's Guardian or Client	Signature of Client's Guardian or Client	Date
_____	_____	_____
Printed Name of Therapist/Witness	Signature & Credentials of Therapist/Witness	Date

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