Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read the following TeleHealth consent and sign below. If you have any questions, please let me know!

1. I understand that I am about to engage in TeleHealth/video sessions with my counselor, Beverly Jewell, LPCC.
2. I understand that the video conferencing technology will not be the same as an in-person session because I will not be in the same room as my counselor. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties.
4. My counselor agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I also agree to inform my counselor if there is another person present during the session or if I wish to tape the session.
5. I understand that there are alternatives to a TeleHealth session available, including the option of finding another counselor to see in-person in my area.
6. I understand that this consent will last for the duration of the relationship with Beverly Jewell, LPCC. I can withdraw my consent for TeleHealth sessions at any time, and my counselor will work with me to find a suitable alternative.
7. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to TeleHealth sessions as they would to an in-person session.
8. I agree to work with my counselor to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.
9. I understand that my counselor may decide to terminate TeleHealth services, if they deem it inappropriate for me to continue treatment through video sessions. If so, my counselor will assist me in finding another provider for in-person care.

By signing this form, I certify:

* That I have read or had this form read and/or had this form explained to me.
* That I fully understand its contents including the risks and benefits of the procedure(s).
* That I agree to participation in TeleHealth/video session(s) with Beverly Jewell, LPCC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s/parent/guardian signature                                            Date