**Informed *C*onsent for Telephone Therapy**

This is designed to allow you to give informed consent for the use of telephone technology for therapeutic services. This is to be used in conjunction with, but does not replace, the Disclosure document that is required of all clients prior to starting therapeutic services.

I understand that therapy conducted online or through telephone is technical in nature and that problems may occasionally occur with connectivity. Difficulties with hardware, software, equipment, and/ or services supplied by a 3rd party may result in service interruptions. Anyone with internet availability or connectivity are outside the control of the clinician and the clinician makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed by telephone. I agree to call my therapist back at the clinical emergency number (719)-761-3206. I agree to take full responsibility for the security of any communications or treatment on my own computer, telephone and in my own physical location. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I understand that there will be no recording of any of the online/phone session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Treatment: I, voluntarily agree to receive online or telephonic therapeutic services for assessment, continued care, treatment, or other services and authorize my clinician to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through my clinician at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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