Consent for Telehealth/Mill Springs Counseling, PLLC
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Client Name_____ Date of Birth_____
Phone_____Email_____

Telehealth uses electronic communications to enable therapist and client easier access to therapy and the convenience of meeting from a location of the client's choosing. Telehealth electronic communications are HIPAA compliant and confidential. Telehealth visits do not cost any more than an in office appointment.

By signing this form, I understand the following:
1. I have read and understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth just as face to face therapy.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth at any time without it affecting my right to future care.

3. I understand to maintain confidentially I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the connections are not adequate for the situation.

5. I have had the opportunity to ask questions or discuss this procedure directly with my provider, and feel my questions have been answered, including risks and benefits.

By signing this form, I give my informed consent for the use of telehealth in my care.

Signature of Client (or person authorized to sign for client)
_____

If authorized signer, relationship to Client _____

Date_____