**Krippa Family Psychological & Wellness Services**

**Client Name:**_____ **Date of Birth:**_____

**Address:**_____

**Date:**_____

**Definition of Telehealth**- Telehealth involves the use of electronic communications to enable Krippa Family Psychological & Wellness Services mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio and video Communication.

I hereby consent to participating in psychotherapy via Google Meet, Doxy.me, or Regroup- HIPAA compliant video conferencing platforms or a combination of face-to-face psychotherapy and Telehealth.

**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.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, **my therapist has the right to break confidentiality to prevent the threatened danger**. Further, 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. 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, my therapist may offer this or I may be referred to a therapist in my geographic area that can provide such services.

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 further attest that since I have chosen this form of communication I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

**I understand that I may revoke this consent at any time by giving written notice. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.**

I agree to use an electronic signature as a legal representation of my written signature *
Yes
No

Please type your name below in this form: