Lisa Alber, LICSW
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LisaAlberTherapy.com

Informed Consent to Participate in TeleHealth Therapy

I _____ hereby consent to engaging in TeleHealth Therapy with Lisa Alber, LICSW as part of my mental health treatment. I understand that "TeleHealth Therapy" includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications such as the telephone, cellular phones, the Internet, and video conference such as Zoom.

I understand that I have the following rights with respect to TeleHealth Therapy:

(1) I understand that telehealth services are completely voluntary and that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) I understand that the dissemination of any personally identifiable images or information from the TeleHealth interaction to other entities shall not occur without my written consent.

(3) I understand that none of the telehealth sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.

(4) I understand that there are risks and consequences from TeleHealth Therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my health information could be disrupted or distorted by technical failures; the transmission of my health information could be interrupted by unauthorized persons; and/or the electronic storage of my health information could be accessed by unauthorized persons. I also understand that the programs listed above have their own policies that might interfere with confidentiality and I am fully aware of the risks associated with working with these programs. In addition, I understand that TeleHealth services may not be as complete as face-to-face services.

(5) I understand that I may benefit from TeleHealth Therapy, but that results cannot be guaranteed or assured.

(6) I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telehealth services.

(7) I understand that if the video conferencing connection drops while I am in a session, I will have additional methods to contact my therapist, such as phone and email.

(8) I understand that if there is an emergency during a telehealth session, then my therapist may call emergency services and/or my emergency contact.

(9) I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. (This will be waived temporarily due to the Coronavirus. Please give as much notice as possible, such as the day before, when possible)

(10) I understand credit card, Venmo or other form of payment will be established before the first session.

Client name (print): _____ DOB:_____

Client/Parent Signature _____ Date: _____

Emergency Contact: _____ Phone:_____