SHEREL GRIFFITHS Therapy & Mediation Services
sherelgriffithstherapy@gmail.com
www.sherelgriffithstherapy.com
(514) 716-7208

Teletherapy Consent Form

I. Teletherapy is the delivery of psychological treatment and consultation provided through interactive internet technologies where the patient and the clinician are not in the same physical location.

II. Clients are expected to attend therapy sessions regularly and require a minimum 48 hours notice for cancellation and rescheduling. Administrative fee corresponding to the hourly rate will be billed for late cancellations and missed appointments outside of the 48 hours policy.

III. A lack of access to the information that might be achieved in a face-to-face visit but not in a teletherapy session may result in misreading of non-verbal body language.

IV. There might be a risk of deficiencies, delays, or failures during the transfer of services due to electronic circumstances.

V. All information provided will be held confidential and will not be disclosed without consent, except where disclosure is required by law. The electronic systems that are used throughout the service incorporate network and software security protocols (encryption) to protect the confidentiality of patient information and data.

By signing below, you acknowledge that:

☐ You have fully understood and accept the terms mentioned above.

_____ _____

First Name/Pronouns **Last Name**

X _____

_____

Date (dd-mm-yyyy)