



# Informed Consent for Teletherapy Services

I consent to engaging in teletherapy services with LifeCycle Family Counseling (LCFC) and understand that teletherapy services include, but are not limited to, consultation, treatment and using interactive audio, video and/or data communications. I understand that teletherapy involves the communication of my medical/mental health information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. I understand that the guidelines surrounding beginning and ending sessions on time and providing my therapist with 24 hours notice prior to a cancellation continue to apply to teletherapy sessions.
3. I understand that there will be no recording of any of the teletherapy sessions 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.
4. Additionally, I understand that no other persons will be present during the teletherapy session unless both of us have consented to their participation.
5. I understand that there are risks and consequences associated from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist that: the transmission of my medical/mental health information could be disrupted or distorted by technical failures; the transmission of my medical/mental health information could be interrupted by unauthorized persons; and/or the electronic storage of my medical/mental health information could be accessed by unauthorized persons.
6. In the event of a technical problem or failure, we agree to contact each other via text or phone to reestablish communication and make a plan for the remainder of our session time.
7. I agree to take full responsibility for the security of any communications or treatment on my computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in secure and private locations so that others cannot hear my conversation.
8. I understand that teletherapy based services may not be as complete as in-person psychotherapy. I understand that if my therapist believes I would be better served by another form of therapeutic services we would discuss the reasons for this assessment and agree on another form of therapeutic provision of services that better meets my needs.
9. Additionally, I understand that in the event that I am in crisis, my therapist may contact my emergency contact and/or direct me to the nearest emergency room.
10. I understand that there are risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse. Likewise, I understand that results from teletherapy cannot be guaranteed or assured.

11. I understand that it is my responsibility to verify that my insurance company will provide reimbursement for teletherapy sessions and in the event that they do not provide reimbursement that I am responsible for the full payment of fees associated with the same that I have negotiated with my therapist.

## **Name**

First Name

Last Name

## **Date**



Month Day Year

## **Signature**

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