Adolescent Family Counseling Center, LLC
350 South Main Street, Suite 23
Cheshire, CT 06412

Teletherapy Informed Consent Form

"Teletherapy" includes consultation, treatment, telephone conversations, and other medical information using interactive audio, video, or data communications. I understand that I have the choice to participate or not. By my choosing to participate in teletherapy session(s) with my therapist, it will be recognized as an acceptance, my providing my Teletherapy Informed Consent without the proximity of my signing this form in person.

In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

In addition, I do understand that teletherapy based services and care may not be as complete as in-person face-to-face services.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential in a manner that parallels to our in-office sessions. Unless agreed upon, I will not include others in the session or have others in the room.

License: I am aware my provider has verified the credentials of provider are valid and up-to-date.

Non-Emergency: I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand I can and should call 911 or proceed to the nearest hospital emergency room for help.

Limitations: I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers. I understand that, although my clinician is offering HIPAA-compliant teletherapy, there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that:
* the transmission of my information could be disrupted or distorted by technical failures;
* the transmission of my information could be interrupted by unauthorized persons; and/or
* the electronic storage of my medical information could be accessed by unauthorized persons.
I am responsible for information security on my computer or other electronic device.

I have read, understand, and agree to the information above.

Client's Name: _____ _____

Client's Signature (or Legal Guardian, if under age 18): _____

Date: ____/____/ 20___