Christina Taylor, LPC, PLLC
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CLIENT INFORMED CONSENT FORM FOR TELEHEALTH SERVICES

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information about telehealth services below.

Risks and Benefits. 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, I will be referred to a therapist in my geographic area that can provide such services.

Confidentiality. 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. There are also no permanent video or voice recording kept of any Telehealth session.

Electronic Communication. I cannot ensure the confidentiality of any form of communication through electronic media, including e-mail and text messages. If you prefer to communicate via e-mail or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Consent to Treatment. By signing this consent form, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form, and have been given appropriate opportunity to address questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive telehealth-based mental health services and I understand that I may stop such treatment or services at any time by providing written notification to Christina Taylor, LPC.

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Client Name	**Client Signature (Parent/Guardian if Under 18)**	**Date**