PHOENIX RISING COUNSELING
28a Mashamoquet Rd. Pomfret Center, CT. 06259
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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that telehealth, alternately known as telemedicine, tele therapy, telecare, etc., includes the use of electronic telecommunication technologies for long-distance patient and clinician contact, care, intervention, monitoring, and more. I also understand that telehealth may involve the communication of my medical/mental health information, both orally and visually.

2. Telehealth has the same purpose or intention as psychotherapy conducted in person. However, due to the nature of the technology used, I understand that telehealth psychotherapy sessions may be experienced somewhat differently than face-to-face psychotherapy sessions.

3. I attest that I am currently residing within Connecticut.

4. I understand that I have the right to withhold or withdraw consent for telehealth services at any time without affecting my right to future care or treatment. Please be advised that there may not be immediate availability for in-person therapy if you decide to opt-out of telehealth.

5. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the Notice of Privacy Practices, Limits of Confidentiality, and Adolescent Service Agreement (where applicable) I received at the start of my treatment at Phoenix Rising Counseling.

6. I understand that there are risks and consequences of participating in telehealth therapy, including, but not limited to the possibility, despite best efforts to ensure high encryption and secure technology on the part of my clinician, 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; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur.

7. I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my clinician believes I would be better served by another form of psychotherapeutic services, I will be referred to a professional in my locality that can provide such services.

8. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that, despite my efforts and the efforts of my clinician, my condition may not improve and, in some cases, may even get worse.

9. I understand that I may benefit from therapeutic services administered through telehealth but that results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

10. I understand that telehealth does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 211 or 911.

11. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth sessions. I acknowledge that I am responsible for providing the necessary computer, telecommunications equipment, and Internet access for my telehealth sessions and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth sessions. It is my clinician's responsibility to do the same on their end.

12. Parents of minors who are receiving therapeutic services through Phoenix Rising Counseling: I understand that my child will require a private space while participating in telehealth sessions. By agreeing to proceed with telehealth-based services for my child, I am acknowledging that I will provide for my child a private space free from distractions or intrusions to mirror the same level of privacy given during in-person psychotherapy sessions. I understand that if I cannot provide for my child a private space free from distractions or intrusions and distractions and/or intrusions occur with relative frequency, my child's clinician may determine that continuing a therapeutic relationship is not appropriate at this time and terminate therapeutic services. Referrals will be provided upon discharge.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS DETAILED IN THIS DOCUMENT.

Client or Parent/Guardian Signature _____Date _____