Informed Consent for Online/Telehealth Therapeutic Sessions

I, (Client name). ____ or Parent/ Legal Guardian of ____ agree and give consent for psychotherapy and treatment by __Candace Edwards, IMH 18911__ using an Internet based platform/software (Doxy.me, Psychology Today) I understand that the platform/software in considered secure and encrypted and meets HIPAA standards of use. I understand that there are certain risks involved in entering into this therapeutic relationship and that those risks have been explained to me.

I understand that online counseling services include, but are not limited to, consultation and treatment using interactive audio, video, and/or data communications. I understand that online counseling services involve the communication of my medical/mental health information to the above referenced provider. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I understand that the laws that protect the confidentiality of my medical information also applies to online counseling services. I understand that the dissemination of any information is under the same HIPAA standards as traditional therapy.

Although rare, I understand that there are risks to Internet based services including, not limited to, the possibility, despite reasonable efforts on the part of the online platform being used and/or Registered Intern, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

By participating in online therapeutic services, I am aware of potential benefits and risks. Some benefits may include improved access to services, being able to choose the therapist I want with specialty experience, the convenience of not having to travel to a therapist and using whatever means of communication I am comfortable with (for my child, if applicable). Although risks are rare, I am aware there are possible risks which include that the information I am able to give may not be sufficient for a diagnosis, that there may be delay in response from my therapist due to technical failures

or unforeseen events, and that I may not be able to respond to the Registered Intern due to my own technology failures or unforeseen events. I understand that the Registered Intern may not be able to provide certain services to me.

Informed consent continues throughout the course of therapy and the Registered Intern will continue to talk with me about risks, benefits or educate me on the process of therapy as we go along. I agree to pay the stated cost for services, and understand that there are refunds under certain conditions (i.e. if technology fails on the part of the Registered Intern and session was not able to be completed.

The Registered Intern has disclosed her credentials as a Registered Mental Health Counseling Intern in the state of Florida, pursuing licensure and is under supervision by a Qualified Licensed Mental Health Counselor.

By signing below, we have read, understood and agreed to the Statement of Informed Consent for Online Counseling/Telehealth:

Client Printed Name: ____

Client Signature : ____ Date ____________

Parent/Legal Guardian Printed Name: __________________________________

Parent/Legal Guardian Signature: ______________________________________ Date ___________

Registered Mental Health Counseling Intern: _______________________________ Date __________