INFORMED CONSENT TO TELEHEALTH THERAPY

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via Teletherapy (internet or phone) with the clinician listed below:

Client Name: _____ **Clinician**: Monika Domke, Wholeistic You, PLLC

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same law that protects the confidentiality of my 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 abuse and any threats of violence I may make towards a reasonably indefinable 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 written consent.

If part of a group therapy session, I agree to keep group members information confidential.

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 could be disrupted or distorted y technical failures or could be interrupted or could be accessed by a unauthorized persons. In additions, I understand that Telehealth treatment is different form in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic service, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that I can withdraw my consent to Telehealth by providing written notification. My signature below indicates that I have read this agreement and agree to its terms.

_____ _____

Authorized Signature for Client **Date**