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TELEHEALTH CONSENT FORM

I, _____ (herein "Client"), hereby consent to engage in Telehealth with Ann Palik, MA, LMFT (herein "Therapist"). I understand that Telehealth is a mode of delivering healthcare services, including psychotherapy, via communication technologies (e.g., internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's healthcare. By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the **Agreement for Services/Informed Consent Form** which I received from Therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth, including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of Therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. Therapist's preferred Telehealth portal is www.doxy.me, which is a HIPAA-compliant telehealth platform. If, for any reason, www.doxy.me is not available or practicable to use, including in cases of technical difficulties, www.zoom.us or another platform may be used, with option to switch to a telephone session.

4. I understand that miscommunication between myself and Therapist may occur via Telehealth.

5. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

6. I understand that at the beginning of each Telehealth session, Therapist is required to verify my full name and current location.

7. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if Therapist believes I would be better served by in-person therapy, Therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

8. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

9. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor Therapist may record the sessions without the other party's written permission.

10. I have discussed the fees charged for Telehealth with Therapist and agree to them [or for insurance patients: I have discussed with Therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g., co-payments)] and I have been provided with this information in the **Agreement for Services/Informed Consent form.**

11. I understand that Therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that Therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with Therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____
Client Name(s) (please print)

_____ _____
Signature of Client(s) Date