Teletherapy Informed Consent Form

"Teletherapy" may include mental health evaluation/assessment, treatment planning, and therapy using video conferencing. There are potential benefits and risks of video-conferencing that differ from in-person sessions.

I, _____, consent to engage in teletherapy with _____(name of therapist) associated with Milestone Counseling, Inc. as a part of my therapy process and treatment goals. I understand that I have the following rights with respect to teletherapy:

(1) Teletherapy occurs in the state of Minnesota, and is governed by the laws of this state. The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon. If the therapist does not feel that I am in a confidential setting, the therapist has the right to discontinue the session. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(2) I understand that there are risks unique and specific to teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, 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; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

(3) There are mandatory exceptions to confidentiality, as with face-to-face therapy, including, but not limited to: reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law.

(4) If you need to cancel or change your teletherapy appointment, you must notify the clinic in advance by phone.

(5) I accept that it is my responsibility to confirm with my insurance company that teletherapy is a covered service; if it is not covered by insurance, I am responsible for full payment.

(6) I accept that teletherapy is not appropriate for emergency or crisis situations. Your therapist will discuss a safety plan and resources that you can utilize if an emergency or crisis presents itself.

(7) In the event teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

(8) Co-pays are due at the time of the appointment and may be paid in advance with the receptionist or at the time of the appointment with your therapist. It is the client's responsibility to be aware of whether or not they have a copay.

_____ _____

Client Signature Date

_____ _____

Name of Minor Client Relationship to Minor Client