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TELEHEALTH INFORMED CONSENT

Client Name (s): _____ Date of Birth: _____

I hereby consent to engaging in telehealth with Dr. Melissa Hofstetter as part of my psychotherapy. I understand that "telehealth" includes mental/behavioral health care delivery, diagnosis, treatment, medical data transfer, and other psychological services via phone, internet, or other electronic means.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. 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, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an identifiable victim including myself; and where I make my mental or emotional state an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my information could be disrupted by technical failure; interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons. If we experience technological failure or disruption in video conference, I understand that we can continue by telephone. I will contact Dr. Hofstetter back. Dr. Hofstetter will wait for up to 15 minutes for me to call back, and I understand our session will still have to end at the scheduled end time.

4. In addition, I understand that telehealth-based services and care may not be as complete or effective as face-to-face services. I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services I will be referred to a psychotherapist who can provide such services in my area.

5. 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 psychotherapist, my condition may not be improved. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

6. I understand that I have a right to access my medical information in accordance with state laws.

7. In order to be provided telehealth services, I understand that I must provide an emergency plan. In case of emergency, I want the following person to be contacted:

Emergency Contact Name:_____

Emergency Contact's Relationship to me:_____

In the event of an emergency, my preferred hospital name and address:_____

How I would want to get to this hospital if I had to go: _____

8. I agree to provide a credit card that Dr. Melissa Hofstetter will keep on file in a secured place and that my credit card will be billed for each session of psychotherapy and/or for other professional services I consent to with Dr. Hofstetter.

I agree to give at least a 24-hour cancellation notice to my therapist in order not to be billed for the session.

9. I understand that Dr. Hofstetter is not available at all times, but it is reasonable that Dr. Hofstetter will get back to me within the next business day, no matter the means of contact.

10. Email should only communicate administrative information, such as making or cancelling appointments. Do not include any personal or sensitive information in any email communication with Dr. Hofstetter. Do not put your name in the subject line, as this is less private.

11. I understand that Dr. Hofstetter will not "befriend" or "follow" me on social media, like Facebook, Twitter, Instagram, etc. This is simply something Dr. Hofstetter does not do, and I understand not to take this personally.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____