SHELLY WIGGINS LPC
DRIFTWOOD COUNSELING LLC
654 E. MAIN ST
OWOSSO, MI 48867

PATIENT NAME:

DATE:

TELETHERAPY INFORMED CONSENT FORM

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.

(2) Teletherapy occurs in the state of Michigan (USA), and is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist in their Michigan private or personal office setting, where we will meet to do our work.

(3) 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.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my best interest(s), my therapist will explain to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from 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 own electronic device used for any and all teletherapy sessions.

(7) I agree that it is my responsibility to call my insurance company to understand my coverage for mental health services via Telehealth devices. I understand that there may be a time limit to this type of coverage and assume any uncovered fees for services.

I have read, understand, and agree to the information above.

Patient Signature:_____

Name:

Date: