Northshore Clinic and Consultants

INFORMED CONSENT TO TELEALTH

Client's Full Name:_____ DOB:_____ Therapist: _____

Introduction

Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment, thereby increasing accessibility to psychological care. Telehealth platforms utilized by Northshore clinics and consultants LLC are protected by and to end encryption. I hereby consent to participating in psychotherapy via telephone or the Internet (hereinafter referred to as telehealth) with the clinician listed above.

Client Rights

- I have a right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical 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 adult abuse and any threats of violence I may make towards a reasonably identifiable 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 my written consent.
- I understand that while psychotherapeutic treatment of all kinds have been found to be effective in treating a ride 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 understand that there are risks unique and specific to telehealth, including but not limited to the possibility that our therapy sessions or other communication by my therapist to me regarding my treatment could be disrupted by technical failures or could be accessed by unauthorized persons.
- I understand that neither myself, the client, nor my therapist, the provider, will record any Teletherapy sessions without prior written consent.
- In addition, I understand that telehealth treatment is different than in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in person treatment, we will collaborate as to how we can provide such services.

- Finally, I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to telehealth communications by providing written notification to Northshore Clinics and Consultants LLC.

My signature below indicates that I have read this agreement and agree to its terms.

Clients Signature: _____ Date: _____

Clinician Signature: _____ Date: _____