LINDSAY SORENSEN, M.S., LPC, LCDC

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TELEHEALTH INFORMED CONSENT

I _____ (print name of client) hereby consent to engaging in telehealth with Lindsay Sorensen, LPC as part of my therapy. I understand that "telehealth" (also called online counseling) includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

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

1. I have a 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 self and/or an ascertainable victim; and where I make my mental and emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without any written consent.

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 therapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons. I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services, I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

4. I understand that I have a right to access my personal information, the same as I would for face-to-face sessions.

5. I understand that fees and payments for sessions are the same as for face-to-face sessions, and telehealth sessions are subject to the same 24-hour cancellation policy. Please refer to the initial informed consent agreement and professional disclosure statement for more information. Both are available at www.lindsaysorensen.com.

6. I agree to inform my counselor of my accurate location at the beginning of each session, and will provide an emergency contact person, including contact information, in case of emergency.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and am not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies, or the National Suicide Prevention Lifeline at 1-800-273-TALK [2855].

I have read and understand the information provided above. I have discussed these points with my therapist, and all my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this consent document and agree to its terms.

✤_____ _____
Client Signature (or Parent/Guardian if Client is a Minor) Date

✤_____ _____
Counselor Signature Date