Southeast Psych Teletherapy Services
CONSENT FORM

Teletherapy is a form of psychological service provided via secure internet technology. It has the same purpose as psychotherapy conducted face-to-face. Due to the nature of the technology used, Teletherapy services may be experienced somewhat differently than face-to-face treatment sessions. As with most technology, there are benefits and limitations to this kind of service.

Teletherapy is not best suited for clients who are actively at risk of harm to self or others. If this is the case or becomes the case in future, your therapist can refer you to more appropriate services in your local area.

You will need a computer with internet access and webcam ability. You will also need access to a phone in case the internet connection fails.

Client Risks and Rights with Teletherapy:

1. I understand I have the right to withdraw consent at any time. It will not affect my right to further treatment.
2. I understand the therapist has the right, at any time, to determine if teletherapy sessions are not appropriate for my case. Should this be determined, the therapist is obliged to provide me with referral information to other services.
3. I understand the laws and professional standards that apply to regular psychological services apply to Teletherapy services.
4. I understand that insurance companies may or may not cover teletherapy services and that I am ultimately responsible for the balance on my account for any professional services rendered.
5. I understand the same exceptions to client confidentiality policies that exist for regular therapy also apply to teletherapy services. I know I can review my consent for treatment form to review those exceptions.
6. I understand that despite best efforts to ensure high encryption and secure technology, there is always a risk that the transmission could be breached and accessed by unauthorized persons.
7. I understand there is a risk that services could be disrupted or distorted by unforeseen technical problems.
8. I am aware there is a risk of being overheard by anyone near me if I am not in a private room. I understand I am responsible for creating my own comfortable and safe space for the session. It is the responsibility of the therapist to do the same on his or her end. I agree to verify this with my clinician at beginning of session.
9. I understand that due to the nature of the interaction, there may be quality differences that are experienced when compared to face-to-face services. I can provide feedback to my therapist if I find teletherapy insufficient to meet my needs.
10. I may decline any teletherapy services at any time without jeopardizing my access to future care, services, and benefits.
11. I understand this document does not replace other agreements, contracts, or documentation of informed consent.

Client or Guardian Signature	Client (and Guardian) Printed Name (s)	Date

By typing my initials here, I acknowledge that my signature above is a digital representative of my handwritten signature, and as such bears the same weight and responsibility.

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F 704-552-7550
www.southeastpsych.com

15720 Brixham Hill Avenue, Suite 150
Charlotte, NC 28277
P 704-970-4791
F 704-970-4794
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5409 Maryland Way, Suite 202
Brentwood, TN 37027
P 615-373-9955
F 615-373-2001
www.southeastpsychnashville.com

Southeast Psych Teletherapy Services
INFORMATION SHEET

My Therapist is:

My Name: _____

My Date of Birth: _____

My Email Address: _____

My Cell Phone Number: _____

My Preferred Means for Sessions:

- ◯ Phone Call
- ◯ Doxy.me
- ◯ VSee
- ◯ Other:

Local Emergency Center:

Facility Name:_____

Address: _____

_____

Telephone Number:_____

Facility Confirmed by Clinician:

Date:_____ Clinician Signature:_____

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