Pathway Counseling

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Oviedo, FL 32762-0478
Phone: 407-366-5656/ Fax: 407-386-6658

Teletherapy Informed Consent

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 Florida, and is governed by the laws of the state.

3. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment services.

4. 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.

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

6. In the event our teletherapy is not in my best interest, my therapist will explain that to me and suggest some alternative options better suited to my needs. I, the client, have the right to withhold or withdraw using teletherapy at any time without affecting my right to future care or treatment.

7. 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 mechanical 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 computer or electronic device. I am also responsible to make sure there is privacy on my end, so that others are not around to hear our counseling session.

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

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Clients Name

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Client Signature (or Legal Guardian if under age 18) Date