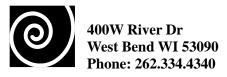
Kettle Moraine Counseling Services



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INFORMED CONSENT TO TELEMEDICINE

Telemedicine 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. Telemedicine platforms

Client Name:	Clinician:
	Telemedicine under the same laws that protect the confidentiality of my sychotherapy. Any information disclosed by me during the course of my
dependent adult abuse and a also understand that if I am therapist has the right to brothe dissemination of any pe	as to confidentiality, including mandatory reporting of child, elder, and any threats of violence I may make towards a reasonably identifiable person. I in such mental or emotional condition to be a danger to myself or others, my eak confidentiality to prevent the threatened danger. Further, I understand that resonally identifiable images or information from the Telemedicine interaction of occur without my written consent.
range of mental disorders, personal	peutic treatment of all kinds has been found to be effective in treating a wide and relational issues, there is no guarantee that all treatment of all clients will while I may benefit from Telemedicine, results cannot be guaranteed or
possibility that our therapy sessions	sks unique and specific to Telemedicine, including but not limited to, the or other communication by my therapist to me regarding my treatment could al failures or could be interrupted or could be accessed by unauthorized
 I understand that neither myself the without prior written consent. 	client, nor my therapist the provider, will record any teletherapy sessions
	edicine treatment is different from in-person therapy and that if my therapist another form of psychotherapeutic services, such as in-person treatment, we rovide such services.
with my therapist and to have any q	rmation provided above. I have the right to discuss any of this information uestions I may have regarding my treatment answered to my satisfaction. I consent to Telemedicine communications by providing written notification to
My signature below indicates that I have rea	nd this Agreement and agree to its terms.
Client Name (print):	

Client Name (Sign): _____ Date:_