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 utilized by KMC clinicians are protected by end to end encryption. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telemedicine) with the clinician listed below:

Client Name: _____ **Clinician**: _____

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telemedicine 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 Telemedicine interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide 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 Telemedicine, results cannot be guaranteed or assured.
- I further understand that there are risks unique and specific to Telemedicine, 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 or distorted by technical failures or could be interrupted 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 Telemedicine treatment is different from 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.
- I have read and understand the information provided above. 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 Telemedicine communications by providing written notification to Kettle Moraine Counseling.

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

Client Name (print): _____

Client Name (Sign): _____ Date:_____