INFORMED CONSENT TO TELEHEALTH

Telehealth 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. Telehealth 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 Telehealth) with a KMC provider.

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth 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 Telehealth 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 Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my provider 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 Telehealth treatment is different from in-person therapy and that if my provider 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. In the event that my provider does not feel they can adequately address my needs virtually I understand that telehealth appointments are not required to be offered. Telehealth availability is at the providers sole discretion.

I understand that it my sole responsibility to find a location to be alone during the visit to ensure privacy on my end. I can expect my provider will also use a location with full privacy for our sessions.

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 Telehealth 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): _____
Date: _____
Client Name (Sign): _____

Parent/Guardian Signature_____

KETTLE MORAINE COUNSELING
400 W River Drive West Bend WI 53090
W62 N281 Washington Ave Cedarburg WI 53012
7280 S 13th Street Oak Creek WI 53154
P: 262.334.4340 F: 262.334.4341 www.kettlemorainecounseling.com

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

Kettle Moraine Counseling is taking steps to reduce the risk of spreading the coronavirus within our offices. Please read this carefully and let us know if you have any questions.

Decision to Meet Face-to-Face

You have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, we may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about if first and try to address any issues. You understand that, if we believe it is necessary, we may return to telehealth for everyone's well-being.

If you decide at any time you would feel safer staying with, or returning to telehealth services, we will respect that decision as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue that may need to be discussed.

Risk for Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness, and possible death. These precautions include staying home when you feel ill or are showing any signs of COVID, as well as staying home if you have had any recent exposure or have tested positive for COVID in the last 10 days. If you do not adhere to these safeguards, it may result in starting/returning to a telehealth arrangement.

If you or I are Sick

You understand that we am committed to keeping you, our staff, and all of our families safe from the spread of this virus. If you show up for an appointment and we believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth if appropriate. If your provider is ill or has tested positive for COVID they will call to give you as much warning as possible. You will not be charged for any appointment your provider cancels as well as any appointments you need to cancel due to illness as long as you give as much notice as possible.

Informed Consent

This agreement supplements the general informed consent also needed before the start of any treatment as well as annually. Your signature below shows that you agree to the terms and conditions above.

Client Name: _____

Client (or parent/guardian) Signature: _____

Date: _____