Molly Richter, LMFT, LLC
Counseling for Individuals, Couples and Families

INFORMED CONSENT TO TELEHEALTH

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 have 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 therapy sessions or other communication could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons. I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of therapeutic services, such as in-person treatment, or that Telehealth is not deemed to be effective, this will be discussed.

I understand and agree to the following information:

I understand that I may need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I understand that in the case of technology failure, I may contact Molly Richter, LMFT, LLC via phone to complete sessions via phone/audio only.

I understand that I am responsible for securing a quiet and private location for telehealth sessions, as Molly Richter, LMFT, LLC will do at her location, and that if privacy is breached during a session, Molly Richter, LMFT, LLC or I, as client, may abruptly end the session as needed and resume contact as soon as possible.

I understand that, as always, if there is an emergency, it will be necessary to dial 911 and pursue emergency or urgent care.

I understand that Telehealth sessions conducted via cell phone or via popular platforms for video chat such as FaceTime or Skype, are not HIPAA compliant and cannot be guaranteed to remain confidential, despite all parties' efforts to ensure privacy. If I choose and consent to participate in sessions via these means I assume all risk and responsibility.

I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Molly Richter, LMFT, LLC and that Molly Richter, LMFT, LLC may release any information to my insurance provider required for processing my claims. If insurance does not cover Telehealth, or I use a self-pay option, I agree to pay the fees outlined in my existing Outpatient Services Contract with Molly Richter, LMFT, LLC.

I have reviewed and agree to all information, policies and procedures outlined in Molly Richter, LMFT, LLC's previously signed Outpatient Services Contract, and understand that these will apply for Telehealth services as well.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Molly Richter, LMFT, LLC. My signature below indicates that I have read this Agreement and agree to its terms.

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 hereby consent to engaging in Telehealth with Molly Richter, LMFT, LLC as part of my counseling services.

_____ _____

Client Signature Date

_____ _____

Client Signature Date