



Client Name: _____

1. I understand that my therapist _____, wishes to engage with me via telehealth/live video sessions(s).
2. My therapist has explained to me how the video conferencing technology will be used to conduct sessions, but they will not be the same as a direct patient/therapist visit due to the fact that I will not be in the same room as my mental health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my mental health care provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my contact information may be shared with other individuals for scheduling and billing purposes.
5. I have had the alternatives to a telehealth session explained to me, and I am choosing to participate in a live video session with my therapist, _____.
6. In an emergency consultation, I understand that it is the responsibility of my therapist to advise those present with me or police/medical emergency services for my safety and/or the safety of others.
7. I understand that in order for my mental health provider to bill for services rendered a credit card or debit card will need to be safely stored on our TheraNest payment system.

By signing this form, I agree: (Please initial)

___ That I have read or had this form read and/or had this form explained to me.

___ That I fully understand the risks, benefits, and limitations of therapy via live video sessions.

___ That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Signature: _____ Date: _____