Informed Consent for Video Therapy
This consent is in addition to the standard consent for therapy and not intended to be exhaustive.

Please read the following video therapy consent and sign below. If you have any questions, please let your therapist know, so we can get them answered and an informed decision can be made.

1. I understand that I am about to engage in a telehealth therapy session with my provider at Arrowhead Family Systems.

2. I understand that the using technology will not be the same as an in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.

3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth therapy session if it is felt that the technological connections are not adequate for the situation.

4. My provider and I mutually agree to inform each other and obtain the necessary consent if another person is present during the session. Taping sessions will only be allowed under the guidelines in our practices main Consent for Treatment regarding taping sessions.

5. I understand that there are alternatives to telehealth therapy available, including the option of finding another provider to see in-person if available in my area.

6. I understand that I can direct questions about this telehealth therapy session at any time to my provider.

7. I understand that this consent will last for the duration of the relationship with my provider, including any additional telehealth therapy sessions I may have; I can withdraw my consent for a telehealth therapy session at any time.

8. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a telehealth therapy session as they would to an in-person session.

9. I agree to work with my provider to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions and what will happen should we get disconnected before the typical end of the session.

10. I understand that my provider may decide to terminate telehealth therapy services, if they deem it inappropriate for me to continue therapy through this means.

By signing this form, I certify:

● That I have read or had this form read and/or had this form explained to me.
● That I fully understand its contents including the risks and benefits of the procedure(s).
● That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.
● That I agree to participate in a telehealth therapy session(s) with this practice.

Signatures: Patient (s) ____ Date : ___________________

____ Date : ___________________

In the case of a minor child, please specify the following:

Full name of minor __________________________ DOB ____________ Relationship _______________

Therapist Name: Anissa Hamlin, M.S., LAMFT

Signature: ____ Date _____________________________

For therapist use only – discussion of this consent has been included in the initial session and questions have been answered and/or additional materials have been given to client as requested.

____ Date ____
Dr. Kimberly Bailey, DBH, LMFT 10-200