Consent for Teletherapy

I, _____, (client or guardian) hereby consent for _____ (client) to participate in teletherapy with IAG Behavioral Health Center, as part of my psychotherapy. I understand that teletherapy is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a practitioner and a client. I understand the following with respect to teletherapy:

1. I understand that teletherapy services are available only to those clients who are residents of Illinois, as therapists are only permitted to provide clinical services to those living in the state where the therapist is licensed.
2. I understand that I have the right to withdraw consent at any time without affecting my right to available future care.
3. I understand that there are risks, benefits, and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures and/or limited ability to respond to emergencies.
4. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) in traditional psychotherapy also apply to teletherapy services.
6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy services are not appropriate and a higher level of care is required.
7. I understand that during a teletherapy session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, we will communicate about rescheduling the session.
8. I understand that IAG Behavioral Health Center needs to know my location and I agree to inform my therapist of the address where I am at the beginning of each session.
9. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in the case of an emergency.
   Emergency Contact:
   First and Last Name:_____ Relationship:_____
   Address:_____ Phone:_____

   I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____	_____	_____	_____
Client / Guardian Signature	Print Name	Relationship to client	Date