Client-Informed Consent for Online Therapy Services

I ________________________________ (adult client's/parent or guardian's name) hereby consent to engage in online counseling/teletherapy services for myself/my child with Shirin Shahrokhi MA, LMFT. I understand that online counseling/teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental health information, both verbally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and understand that my therapist will explain these to me in detail if I wish.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Shirin Shahrokhi MA, LMFT, that: the transmission of my information could be disrupted or distorted by technical failures.

** I understand that if the teletherapy session does get disconnected, Shirin Shahrokhi will call me back by phone, to complete our session.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911; or proceed to the nearest hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free, 24-hour support.

7. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my online counseling/teletherapy sessions, and (b) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session.

8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

Client Printed Name: ____

Parent/Guardian Printed Name (if child client): ____

Client/Parent Signature: ____

Date: ____