



Teletherapy Consent Form

I hereby consent to engage in teletherapy with _____ at GIFT Counseling Center for Wellness. I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually. I understand that I have the following rights with respect to 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 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 both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Disclosure and Consent which I received when I initiated services with my therapist at GIFT.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and confidentiality cannot be guaranteed.
4. I understand that teletherapy-based services and care may not be as complete as face-to-face services, and if the therapist believes I would be better served by another form of therapeutic service, (e.g.: face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that I may benefit from teletherapy, but the results cannot not be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. The therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. 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.
6. I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; the information security on my computer; and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my therapy sessions.

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

Client or Guardian Signature

Date

Clint Printed Name

GIFT Counseling Center for Wellness, LLC
119 Manly Street
Greenville, SC 29601