

*A Multi-Specialty Psychological Group*

**Informed Consent for Online Teletherapy and Coaching**

I hereby consent to engage in online psychotherapy services or coaching with the psychotherapist(s) I have selected through Cognitive Dynamic Therapy Associates. I understand that online therapy services include, but are not limited to, consultation, treatment and using interactive audio, video or data communications. I understand that online therapy services involve the communication of medical/psychological information both orally and visually, to health care practitioners that may be located outside my local area or state.

**I understand that I have the following rights with respect to online therapy services:**

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled
2. The laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. I also understand that the disseminations of any personally identifiable images or information from the online counseling services to researchers or other entities shall not occur without my written consent.
4. I understand that the teletherapy program is HIPPA compliant which means it provides an industry standard of security. Nevertheless I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapists that: the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. In addition I understand that online therapy services may not be as complete as face-to-face services. I also understand that if the counselor believes I would be better served by another form of service (e.g. face-to-face therapy) I may be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy services and that despite my efforts and the efforts of the therapist, my condition may not improve, and in some cases may even get worse.
6. I understand that I have a right to access my medical information and copies of medical records in accordance with the HIPAA privacy rules and applicable state law.
7. I understand that if I use email that confidentiality of emails cannot be fully guaranteed
8. I understand that emergency coverage will be available through a local Cognitive Dynamic Therapy Associates’ therapist or by contacting the Resolve Crisis Network at (888) 796-8226 or 911.

**I have read and understand the information provided above.**

**Signature Date**