ETHERAPY CONSENT FORM

NAME:_____AGE:_____BIRTHDATE:_____

EMAIL:_____

ALTERNATIVE EMAIL:_____

PHONE:_____ALTERNATIVE PHONE:_____

ADDRESS:_____

_____

EMERGENCY CONTACT:

NAME_____RELATIONSHIP_____

PHONE:_____

ALTERNATE:
NAME_____RELATIONSHIP:_____

PHONE:_____

THESE CONTACTS ARE ESSENTIAL EXPECIALLY DUE TO THE REMOTE ASPECT OF DISTANCE THERAPY. CONFIDENTIALITY IS CRITICAL, AND SO IS SAFETY !

I _____hereby consent to engage in e-therapy, teletherapy with Lisa Smith. I understand that the same confidentiality regulations apply to this form of treatment as to traditional health records.

I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner. Should an interruption of contact occur, please be aware that every effort will be made to contact you, via, email, phone call, even physical mail.

PLEASE READ AND SIGN THE CONSENT FORM. THE DETAILS ARE IMPORTANT.

Signature date