**Remote/Telehealth Informed Consent**

Utilizing remote or telehealth therapy means conducting therapy sessions on a HIPPA secure platform through the internet or cellular device via live-video conferencing. This is not a requirement and is voluntary. Benefits of telehealth include continuing movement toward your counseling goals in a convenient place of your choosing, saving time in travel, and navigating illnesses and inclement weather. Risks of telehealth include potential interruption, unauthorized access, and technical difficulties. There is no additional fee for this service. To participate in telehealth therapy, you will need to access a link provided by your therapist to enter their virtual waiting room. From there, your therapist will admit you into session. Oregon’s telemedicine parity law mandates private insurers and state employee health plans to pay specifically for live video-telemedicine. Your insurance company is the final word on paying for sessions. Your sessions will be billed as normal, at the normal rate.

1. I understand that telehealth conferencing technology will not be the same as in-person sessions with my provider due to the fact we will not be in the same room. I also, understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions throughout the session.
2. I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that I or my provider can discontinue telehealth therapy session if it is felt the telehealth conferencing connections are not adequate for the situation or for any other reason.
3. My provider agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my provider if there is another person present during the session.
4. I understand there are alternatives to telehealth sessions available, including the option of finding another provider.
5. I understand that I can direct questions about telehealth session at any time to my provider.
6. I understand that this consent will last for the duration of the relationship with my provider including any additional telehealth therapy sessions I may have. I can withdraw consent for telehealth therapy at any time.
7. I understand that the same confidentiality protections, limits to confidentiality, and rules regarding my records apply to a telehealth therapy session as they would to an in-person session.
8. I understand that my provider will not record telehealth sessions. I also agree not to record telehealth sessions.

By signing below on behalf of myself, or a minor I am the legal guardian of, I am consenting to remote/telehealth treatment and understand that this treatment is voluntary. I understand that my therapist has reviewed state and federal laws and that this service is in compliance with those laws.

Client Signature: Date:

Guardian Signature: Date: