



LiveWell
Therapy Associates, LLC

TELETHERAPY CONSENT FORM

Teletherapy provides therapy services using interactive video conferencing tools, such as Google Meet, in which the therapist and the client are not at the same location. Teletherapy will allow the client to receive psychotherapy without the need to visit the office or travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in clinical judgment. Alternatives to teletherapy include traditional face to face sessions.

Your rights:

- 1) I understand that the laws that protect the privacy and confidentiality of clinical information also apply to teletherapy
- 2) I understand that the video conferencing program(s) used is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
- 3) I have the right to withdraw my consent to the use of teletherapy during the course of my care at any time
- 4) I understand that Livewell Therapy Associates has the right to withhold or withdraw consent for the use of teletherapy during the course of my care at any time
- 5) I understand that all rules and regulations which apply to the practice of therapy in the Commonwealth of Massachusetts also apply to teletherapy.

Your Responsibilities

- 1) I will not record any teletherapy sessions without the prior written consent of Livewell Therapy Associates, and I understand that Livewell Therapy Associates will not record any teletherapy sessions without my consent
- 2) I will inform Livewell Therapy Associates if any other person can hear or see any part of our session before the session begins. Likewise, my therapist will inform me if any other person can hear or see any part of the session before it begins.
- 3) If my Initial Consultation is conducted via teletherapy, I may be asked to verify my identity to Livewell Therapy Associates before the session begins.

Your signature below indicates that you have read and understand the information provided above regarding teletherapy, and that you authorize Livewell Therapy Associates to use teletherapy in the course of diagnosis and treatment.

X _____
Client Signature

X _____
Date