Informed Consent to Telehealth Services

The following form hereby allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment.

I,_____, hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with Shana Frenkel, LCSW-C.

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy as delineated in the Health Insurance Portability and Accountability Act (hereinafter referred to as HIPAA). Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

Exceptions to confidentiality include mandated reporting of child, elder, and dependent adult abuse, as well as any threats of violence I may make towards another identifiable persons, as indicated by law. I understand my therapist has the right to break confidentiality to prevent abuse and harm. I also understand that if I am a condition to be a danger to myself and/ or others, my therapist has the right to break confidentiality to prevent harm and danger. Furthermore, I understand that no information, images or communication from Telehealth sessions will be disseminated to other entities without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured due to the fact I wil not bein the same room as my therapist. I understand there

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures and/or technical difficulties, or could be interrupted or could be accessed by unauthorized persons, despite using a secure HIPAA compliant platform. I understand that my therapist or I can discontinue Telehealth services if I would be better served through another form of therapeutic services, such as in person sessions, in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Healing Harmony Health and Wellness with Shana LLC. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Client's signature (If under 18, legal guardian) Date