Informed Consent for Telehealth Sessions

I, _____, hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as "telehealth") with my therapist, Davorka Marovic-Johnson, M.Ed, LPC.

I understand that telehealth allows my therapist to diagnose, consult, treat, transfer mental health data, and educate using interactive audio, video, or data communication regarding my treatment. I understand that telehealth may also involve the communication of my medical/mental/behavioral information to health care practitioners located in Missouri or outside of Missouri to further my diagnosis and treatment or to insure payment for treatment. I understand that 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. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting a child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to any other entities shall not occur 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 telemedicine, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to telemedicine, 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 or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telemedicine treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that I have a right to access my medical information and copies of medical records in accordance with applicable Missouri law.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

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

_____

Signature of patient or guardian of patient Date

_____

Signature of provider/psychotherapist Date