

Teletherapy Informed Consent Form
David L. Thomas, Ph.D., LMHC

I [print your name or names here] _____ hereby consent to engaging in teletherapy via Doxy.me, Zoom, telephone or other electronic means with David L. Thomas, Ph.D., LMHC, as part of my participation in counseling, assessments, or evaluations.

I understand that “teletherapy” includes the practice of consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that if this session is for the purpose of consults or evaluations required by my attorney, courts, or other agencies teletherapy also may involve the communication of my personal medical/mental health information, both orally and visually, through electronic means, to health care practitioners located in Florida or, sometimes, outside of Florida.

I understand that I have the following rights with respect to teletherapy:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. Should I do so, I will not risk the loss or withdrawal of treatment benefits to which I would otherwise be entitled.
- (2) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to: reporting child, elder, and dependent adult abuse; or expressed threats of harm towards one’s self or towards an ascertainable victim. I also 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.
- (3) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
- (4) I also understand that there are inherent risks and consequences from teletherapy, including, but 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; and the transmission of my medical information or treatment could be interrupted or accessed by unauthorized persons.
- (5) I understand that teletherapy-based services and care may not be as complete as in-office services in some instances.
- (6) Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy treatment, and that despite my efforts and the efforts of my therapist, my condition may not immediately improve, and in some cases may even decline. I have read and understand the information provided above. I will be given the opportunity to discuss any and all of my current questions with Dr. Thomas.

Signature of client

Date

Signature of partner/spouse/significant other

Date