Cindi Stoneman, MA, LPC
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TeleHealth Informed Consent Form

I _____ hereby consent to engaging in telehealth with Cindi Stoneman, MA, LPC (provider) as part of my psychotherapy treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical and clinical data, and education using interactive audio, video, or data communications, including the use of telephone, cellular phone, Internet, email, text, IM, and programs such as Skype and Face Time. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Arizona or outside of Arizona.

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

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my psychotherapy 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; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist/provider, that: the transmission of my medical information could be disrupted or distorted by technical failures. Also, the transmission of my medical information could be interrupted or accessed by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist/provider believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to psychotherapists who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of my medical records in accordance with Arizona law.

(6) I understand that telehealth services will not be billed through insurance by the provider. Payment must be made at the time of provision of services and per agreement with the psychotherapist/provider.

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TeleHealth Informed Consent Form - continued

I have read and understand the information provided above. I have discussed it with my psychotherapist/provider, and all of my questions have been answered to my satisfaction. By my signature below, I understand the risks and benefits related to the use of telehealth services and agree to utilize and participate with the use of telehealth services with the psychotherapist/provider named above.

Signature of client	Date
Signature of psychotherapist/provider	Date