I hereby consent to engaging in telemedicine with **Susan G. Schmitz, LISW or Sarah K. Anderson, LISW of Interplay Counseling Services**, as part of my psychotherapy. I understand that telemedicine and teletherapy includes the practice of behavioral/mental health care delivery, using interactive audio, video, or data communications.

The use of telemedicine services is to increase the access to services in the case of extreme weather, illness, or other events that may prevent face-to-face delivery of services. An important part of therapy is sitting face-to-face with an individual, where non-verbal communication (body signals) are readily available to both therapist and patient/client. Without this information, therapy delivered via audio or video may be slower to progress or less effective. Because teletherapy is relatively new, and there is very little research on it, it is important that you are aware that teletherapy may or may not be as effective as in-person therapy.

Patients using telemedicine are receiving services from Interplay Counseling Services offices unless unforeseen circumstances prevent that. The therapist will inform the patient if this occurs, and will describe the steps taken to ensure confidentiality.

I understand that as a patient I have the following rights and responsibilities with respect to telemedicine:

(1) To withhold or withdraw consent at any time without affecting my right to future care.

(2) The laws that protect the confidentiality of my Protected Health Information (PHI) also apply to telemedicine with the same exceptions I agreed to in the original Consent to Treatment for face-to-face sessions.

(3) That there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I further agree to conduct my services in a private setting, as if I was attending an in-person session. Therapists agree to use a HIPAA compliant and approved web-based solution to provide the confidentiality and privacy ensured by the profession and by the law.

(4) That telemedicine-based services and care may not be as complete as face-to-face services, and that my therapist may recommend termination of teletherapy.

(5) 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 improve. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Signature of patient/parent/guardian/conservator. If signed by other than patient, please indicate minor/dependent patient, their date of birth, and your relationship to them. (ex. Jane Doe, mother to Jessica Doe, 1/30/2008.)

_____ Date_____