

TELETHERAPY: I further hereby consent to participate in teletherapy as part of my services. I understand that teletherapy health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to teletherapy health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (“PHI”) also apply to teletherapy unless an exception to confidentiality applies.
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy health services are not appropriate and a higher level of care is required.
- 6) I understand that during a teletherapy health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 630-349-6500 to discuss since we may have to re-schedule.

EMERGENCY PROTOCOLS: You agree to provide your location in case of an emergency to Bette L. Hunt. You agree to inform *Bette L. Hunt* of the address where you are at the beginning of each session. I will require that an emergency contact person may be contacted in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

SESSIONS/CANCELLATION POLICY: Therapy sessions are generally between 45 to 60 minutes long, although the precise length may vary. Please arrive on time as you use your own time when you arrive late for an appointment, if you are late your appointment, time will not be extended.

Signature: _____ Date: _____

Printed Name: _____