TELEHEALTH INFORMED CONSENT
For Services with Beth Christopherson, LCSW, PLLC

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive video, audio or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with Beth Christopherson, LCSW.

I understand I have the following rights under this agreement:

_____I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
• It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
• Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
• Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____I understand that I can withdraw my consent to Telehealth communications by providing written notification to Beth Christopherson, LCSW, PLLC.

_____I understand that I must be in the state of Texas during the entire telehealth psychotherapy session with Beth Christopherson, LCSW, PLLC.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

Beth Christopherson, LCSW, PLLC
4545 Post Oak Place, #210
Houston, TX 77027
832-478-8897

BETH CHRISTOPHERSON
LCSW, PLLC

_____There are by law exceptions to confidentiality, including mandatory reporting of child, elder and dependent adult abuse.

_____To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

Printed Name: _____

Client Signature: _____ Date: _____

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