Natalie Kollross, Psy D
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Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Natalie Kollross, Psy D as part of the therapy process and treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communication.

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

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to 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 Natalie Kollross, Psy D that; the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to another mental health professional that can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. All attempts to keep information confidential while using Doxy system will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with this communication system. Signing this form shows an awareness of these issues and a decision by this client to use this system for telehealth services. I will not hold Natalie Kollross, Psy D or its staff liable for gatherings or use of client information by this service provider.

5) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in a crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrollable psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the crisis line at 1-800-273-8255.

_____ _____

Signature of client/parent/guardian Date

_____ _____

Printed name of client/parent/guardian Relationship to patient