

**Amy S. Clark, Psy.D.**  
**Clinical Psychologist**  
**P.O. Box 12808**  
**Everett, WA 98206**

TELETHERAPY INFORMED CONSENT

I \_\_\_\_\_ hereby consent to engage in Teletherapy with Amy S. Clark, Psy.D. I understand “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversation, interactive audio, video or date communications. I understand that teletherapy also involves the communication of my medical and mental health information, both orally and visually.

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

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 teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the Informed Consent statement I reviewed and signed at the beginning of my treatment.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Clark, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I understand that if Dr. Clark believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional 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 psychologist, my condition may not improve, and in some cases may even get worse.
5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. I accept that teletherapy does not provide emergency services. Dr. Clark and I will or have discussed an emergency response plan. If I am experiencing an emergency situation, I understand I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-8255 or the Snohomish County Crisis Line at 425-388-7215.
7. I understand that I am responsible for:
  - a. providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions.
  - b. the information security on my computer
  - c. arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session

8. I understand that I am agreeing to an individual teletherapy session. I will not include others in the session or have others in the room unless agreed upon prior to the appointment.
9. I understand that while email and text message may be used to communicate with Dr. Clark, confidentiality of emails and text cannot be guaranteed.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state laws.
11. I understand that I am responsible for confirming with my insurance company that teletherapy will be reimbursed. If my insurance does not cover electronic psychotherapy sessions I am solely responsible for the entire fee of the session.

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*I have read and understand the information provided above and have received a copy for myself if desired.*

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Date

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Client Signature

