Client Name: ______________________________ **Date:** _______________

1. I understand that KPCC Counseling has offered me the ability to engage in telemedicine consultation and services.

2. My therapist at KPCC Counseling has explained to me how the phone and/or video conferencing technology will be used for these services, and that this will not be the same as a direct counseling visit due to the fact that I will not be in the same room as my therapist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

5. I understand that all other agreements with my therapist and KPCC Counseling are still in place.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me

· That I fully understand its contents including the risks and benefits of the procedure.

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client's Signature or digital initials _____________________________

Date: _____________________

Therapist: ____