

*Catherine C. Olson Counseling, LLC*

*Teletherapy by appointment: <https://doxy.me/catherineolson>*

**INFORMED CONSENT TO TELETHERAPY**

Teletherapy allows my therapist/counselor to diagnose, consult, treat, and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy by telephone or the internet (hereafter referred to as Teletherapy) with the clinician listed above.

Client Name \_\_\_\_\_

Clinician \_\_\_\_\_

1. "Teletherapy" includes consultation, treatment, emails, telephone conversations, and medical information using interactive internet video or data communications.
2. Teletherapy occurs in the state of Wisconsin and is governed by the laws of the state. In a manner of speaking, I am using this modality to visit my therapist in their Wisconsin office, where we usually meet to do our work.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.
4. I accept that teletherapy does not provide emergency sessions. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
5. In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest alternative options better suited to my needs.
6. I understand there are risks and consequences from teletherapy, including but not limited to the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions regarding my treatment answered to my satisfaction. I also understand that I can withdraw my consent to Teletherapy communication by providing written notification. My signature below indicates that I consent to the terms.

\_\_\_\_\_  
Authorized signature for Client

\_\_\_\_\_  
Date



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