Eberhart Counseling, LLC
633 Maple St., Ste 2, Box 6
Contoocook, NH 03229
(603) 731-4065
eberhartcounseling@gmail.com

INFORMED CONSENT TO TELEHEALTH

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds have been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy sessions or other communication 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 understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of therapeutic services, such as in-person treatment, this will be discussed.

I understand and agree to the following information:

I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smartphone device with a good cellular connection at home or at the location deemed appropriate for services. I understand that in the case of technology failure, I may contact Ellen Eberhart,LCMHC, MLADC via phone to coordinate alternative methods of treatment.

I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Ellen Eberhart, LCMHC, MLADC, and that Ellen Eberhart, LCMHC, MLADC, may release any information to my insurance provider required for processing my claims. If insurance does not cover Telehealth, or I use a self-pay option, I agree to pay the fees outlined in the Information packet.

I have reviewed and agree to all information, policies and procedures outlined in the Information Packet, and understand that these will apply for Telehealth services as well.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Prepare to Change. My signature below indicates that I have read this Agreement and agree to its terms.

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 I may have regarding my treatment answered to my satisfaction. I hereby consent to engaging in Telehealth with Ellen Eberhart, LCMHC, MLADC, as part of my counseling services.

_____ _____

Client Signature Date