

Daniela Roher, PhD LPC

Informed Consent for Treatment using Teletherapy Services

I, _____, agree to participate in teletherapy with Daniela Roher, PhD LPC.

I understand that “teletherapy” or “telepractice” means providing behavioral health services through interactive audio, video or electronic communication that occurs between a behavioral health professional and the client, including any electronic communication for evaluation, diagnosis, and treatment, including distance counseling, in a secure platform.

This means that all my therapy sessions will be provided electronically, not face to face.

Dr. Roher has explained how the teletherapy system works and how it will be used for my treatment.

Dr. Roher has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.

I understand that Dr. Roher will not be physically present during my teletherapy session. Instead, we will see each other electronically.

I understand there are potential risks to telepractice including technological and other interruptions, unauthorized electronic access, and technical difficulties. Unlike in an office setting, Dr. Roher cannot guarantee the confidentiality of the location that I choose for conducting teletherapy. In addition, the use of technology in any setting, including therapy, carries with it inherent confidentiality risks. I understand that Dr. Roher or I can discontinue the telepractice visit if it is felt that the connection is not adequate for the situation. I understand that I may benefit from telepractice, but that results cannot be guaranteed or assured.

I understand that I still may need to see a specialist in person.

I agree to use the video-conferencing platform selected for my virtual sessions, and its use will be explained to me. The platform used by Dr. Roher is a HIPAA-compliant ZOOM program that is end-to-end encrypted.

I need to use a webcam or smartphone during the session.

It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

It is important to use a secure internet connection rather than public/free Wi-Fi.

It is important to be on time. If I need to cancel or change my tele-appointment, I must notify Dr. Roher 24 hours in advance. In case of no-show, the same rules apply as to in-person sessions.

In cases where teletherapy does not involve video (such as phone therapy), Dr. Roher will identify me by using voice recognition and confirmation of my date of birth to ensure confidentiality. I understand that Dr. Roher reserves the right to confirm other identifying information if she believes it necessary to confirm my identity. In addition, at the beginning of each session regardless of method of telehealth delivery, Dr. Roher will ask to confirm my physical location and that my local emergency contacts have not changed.

We will have a back-up plan (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems.

Emergency procedures will be the same as previously stated in the Informed Consent Agreement that I signed at the beginning of treatment. I understand that if I feel unable to keep myself safe or in the event of an

emergency, I should call or text 988 (National) or call 602-222-9444 (Maricopa County) or go to my nearest emergency room and ask to speak to the psychiatrist or psychologist on call.

I have had a direct conversation with Dr. Roher about the risks and benefits related to the utilization of telepractice and had the opportunity to ask questions regarding this option. I acknowledge my questions have been answered.

I have the option of revoking this consent at any time telepractice services are no longer needed or beneficial.

I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with Arizona law. I have read and understand the information provided above. I have discussed it with Dr. Roher, and all of my questions have been answered to my satisfaction.

Name (printed)

Date of Birth

Signature of Client

Date

Relationship (If other than Client; Parent/Guardian/Conservator)

Daniela Roher, PhD, LPC

Date

LOCAL EMERGENCY CONTACT

Please provide the name and phone number of a local emergency contact (someone in the same location or nearby to where you will be participating in teletherapy).

NAME: _____

PHONE: _____

RELATIONSHIP TO CLIENT: _____