Consent for Teletherapy
Spectrum Psychotherapy Centers, LLC

I give consent to engage in teletherapy services through Spectrum Psychotherapy Centers, LLC. I understand that teletherapy is the practice of psychotherapy, including diagnosis, consultation, treatment, transfer of clinical / medical data, and education using interactive audio, video, telephone, or data communications. I understand that whenever possible, a secured HIPAA compliant platform will be utilized. I agree that I will continue to be responsible for my payments. I agree to not record teletherapy sessions and understand that sessions will not be recorded. I understand that this consent is an addendum to the Office Policies and Agreement Form that I have already signed with Spectrum Psychotherapy Centers, LLC. I understand that I have the right to withdraw my consent for teletherapy at any time. I understand that I may benefit from teletherapy but that results can not be guaranteed or assured. I understand that reasonable efforts will be made to maintain confidentiality through this platform. I also understand that there are potential risks, including the possibility that the transmission of my information could be disrupted or distorted by technical failures, and / or the transmission of my personal information could be interrupted by unauthorized persons. I also understand that telehealth based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions, I will be referred to other professionals or services. I also agree that if my therapist has concerns for my safety or the safety of others, that I will call 911 or present myself at the nearest emergency room. I understand that the laws that protect my confidentiality in an office-based setting also apply to teletherapy, and that the exceptions to confidentiality still apply. I have read and understand the information provided above and give my informed and willful consent to treatment using this platform.

I have read this information, understand, and give consent to teletherapy.

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Name of Patient (Please Print)

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Signature of Patient or Guardian (if patient is a minor)

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Date