Integrative Health Partners LLC
30 N Michigan Avenue, Suite 1008
Chicago IL 60602

CONSENT FOR TELETHERAPEUTIC SERVICES

This document contains important information about our professional services and business policies concerning telecommunications therapy services. There are potential benefits and risks of teleconferencing (e.g. technical limits to patient confidentiality) that differ from in-person sessions. Please discuss these in detail with your therapist.

CONFIDENTIALITY
Confidentiality still applies for teletherapy services, and nobody will record the session without the permission of the other person(s). The tele-conferencing platform selected for our virtual sessions will have appropriate technical safeguards. It is important to use a secure internet connection rather than public/free Wi-Fi. It is also important to be in a quiet, private space where you can speak freely without fear of being overheard.

PRACTICALITIES

You will need to use a webcam, tablet, or smartphone for a videoconferencing session. We will need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. We also need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.

All of our normal administrative policies concerning scheduling and billing will apply. See Integrative Health Partners' "Psychotherapist-Patient Services Agreement" for more information. You should confirm with your insurance company that the teletherapy sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

APPROPRIATE USE

Your therapist may determine that due to certain circumstances, teletherapy is no longer in your best interest. Should this occur, your therapist will discuss it with you. It will often be best to resume in-person sessions.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Printed Name_____

Signature_____ Date_____

Therapist Name_____

Signature_____ Date_____