WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 330
Burlington VT 05401

TELE-HEALTH CONSENT FORM

I consent to the following parameters regarding participation in tele-therapy with Aida Luce from Waters Edge Psycotherapy. Ms. Luce and I have discussed these. I understand that I can discontinue tele-therapy at any time, with simple notification to Ms. Luce.

1. In practicing tele-therapy, Ms. Luce shall comply with all the rules of professional conduct and with requirements incurred in state and federal statutes relevant to the practice of psychology.
2. The client and Ms. Luce have agreed that tele-therapy is the most appropriate method to conduct therapy given the following specific limitations for practicing psychotherapy in office.
3. Ms. Luce has determined that the condition being diagnosed and/or being treated is appropriate for tele-therapy.
4. The tele-therapy will be conducted using a video-conferencing platform that is encrypted in order to protect the client's privacy. It is possible that client privacy may be compromised if the video-conferencing platform is compromised, an event out of the control of Ms. Luce.
5. If the client requires urgent contact with Ms. Luce, the client will contact Ms. Luce through phone numbers provided rather than the video-conferencing platform.
6. If the client experiences a life-threatening emergency, the patient will contact emergency services or go to the nearest hospital emergency department.
7. The client's clinical file will be kept secure and separate from the video-conferencing program.
8. My signature allows Ms. Luce to bill my insurance when appropriate for tele-therapy.
9. I understand that text messaging is only for making or cancelling appointments.

Client signature_____Date_____

Client printed name_____ Therapist_____