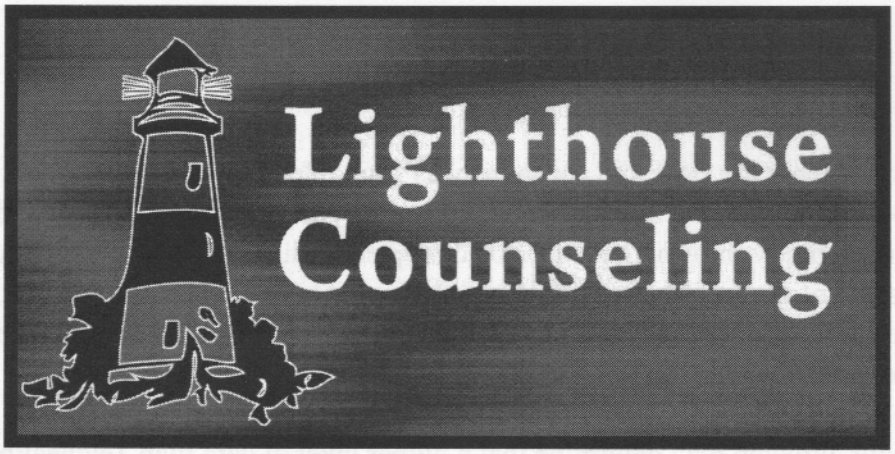

611 A Longhill Road, Groton, CT 06340
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INFORMED CONSENT TO TELEHEALTH

Telehealth allows Lighthouse clinicians/practitioners to diagnose/evaluate, consult, treat, educate, and manage my care using interactive audio, video or data communication. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with my clinician:

Client Name: _____

Client Date of Birth: _____

This form is an addendum to the office policy signed at the time of intake and those rights and responsibilities remain in place.

I understand I have the following rights under this agreement:

1. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy and evaluation/ medication management appointments. Any information disclosed by me during the course of my treatment, therefore, is generally confidential.
2. 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 sharing of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

3. I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

4. You or your clinician may determine that a higher level of care than Telehealth is required to meet your unique treatment needs, at which time a referral will be made to the appropriate provider.

5. Refusal to participate in telehealth if no other type of service is available due to office closure, will result in referral to a higher level of care.

6. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

I have read and understand the information provided above. I have the right to discuss any of this information with my clinician and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications at any time verbally and in writing.

My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature: _____

Signature for Parent/Guardian (if client is under 18): _____