

## Informed Consent to Telehealth

I, \_\_\_\_\_, consent to participating in mental health services with Maleka Walters, LMFT through teletherapy. I understand the laws of confidentiality applies as it would in a face to face therapy session. Exceptions to confidentiality include reports of abuse, threats of harm to self or others, and court proceedings.

To eliminate any risks, I will make reasonable efforts to participate in sessions in a quiet and secured location without any distractions.

I will be provided with a secured link to connect to therapy sessions with my provider. In the event there are issues with the connection, other alternatives will be made.

I agree to not record the sessions.

I am fully responsible for contacting my insurance to ensure teletherapy is covered.

I am fully responsible for any service my insurance does not cover. (*Refer to Counseling Agreement/Informed Consent*).

If I am responsible for any payment, it will be collected at the time of your session.

I understand that if my provider determines that face to face sessions are more appropriate for my care, I will be referred to a different provider that offers in person sessions.

I have the right to revoke this permission at any time.

I have read and understand the information provided.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Provider Signature

*Maleka Walters, MS, LMFT*  
[www.malekawalters.com](http://www.malekawalters.com)