

# Telehealth Consent Form

Fillable · Required for FaceTime and Google Meet sessions

Type directly into each field. Click 'Submit by Email' when complete. (503) 383-9144 · robert@branching-streams.com

## CLIENT INFORMATION

Client Full Name

Date of Birth

Phone Number

Email Address

Preferred Platform

FaceTime

Google Meet

City and State where you will be located during sessions (must be in Oregon)

## ABOUT TELEHEALTH

Telehealth delivers psychotherapy via video conference. Sessions are equivalent in content and confidentiality to in-person appointments. Robert B. Anderson is licensed to provide telehealth services to clients located anywhere in Oregon.

## RISKS AND LIMITATIONS

Telehealth limitations include: potential technology failures; risk of being overheard if a private space is not secured; limitations on observation of non-verbal cues; and reduced capacity for emergency intervention. By signing, you acknowledge these limitations.

## CLIENT RESPONSIBILITIES — check each to confirm

- I will use a private, confidential location for all sessions
- I will use a reliable internet connection (WiFi preferred)
- I have a backup plan if technology fails (phone call)
- I will provide my physical location at the start of each session
- I will contact 911 or 988 in a mental health emergency

## EMERGENCY PROTOCOL

Your physical address during sessions

Local emergency contact name & phone

## CONSENT

I understand the nature, benefits, risks, and limitations of telehealth services. I consent to receive psychotherapy via telehealth with Robert B. Anderson, LPC.

Client Signature (type name)

Date

**Submit by Email to Robert**

Clicking opens your email app — attach completed PDF and send to robert@branching-streams.com