Consent to Participate in Telehealth Conferencing

I, _____, agree to participate in telehealth conferencing with Dr. Susan Orshan. I understand that some aspects of therapy may be different than it is in face-to-face therapy.

I understand that I expect to participate in face-to-face therapy with Dr. Susan Orshan under normal circumstances, and that telehealth conferencing will be utilized only when face-to-face therapy is not possible.

I understand that Dr. Susan Orshan has taken steps to ensure that our session will be confidential and in accordance with HIPAA regulations.

Name: _____

Date: _____