



**William Arndt, MA, LMFT, LADC**  
**Licensed Marriage and Family Therapist**  
**Licensed Alcohol and Drug Counselor**

As a client receiving behavioral services through telehealth methods, I understand:

Telemental health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location.

1. This service is provided by technology (included but not limited to video, phone, text and email) and may involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
2. I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.
3. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.
4. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
5. My communication with my behavioral health practitioner will not be stored.
6. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services.  
This document does not replace other agreements, contracts, or documentation of informed consent.

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Client Signature

Date

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William Arndt, MA, LMFT, LCADC

Date



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I, the undersigned, agree to participate in technology-based consultation and other health-care related information exchanges with William Arndt, MA, LMFT, LCADC, a behavioral healthcare practitioner (“practitioner”). This means that I authorize information related to my behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner. It may also mean that my private health information may be transmitted from my practitioner’s mobile device to my own or from my device to that of my practitioner via an ‘application’ (abbreviated as “app”).

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer’s computer or network. I am aware that any information I enter into an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

My health care practitioner has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My health care practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to, emotional reactions that may be generated by the technology.

Regardless of the sophistication of today’s technology, some information my practitioner would ordinarily get in in- person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better.

I understand that telehealth consultation(s) are a new form of treatment, in an area not yet fully validated by research, and that they have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

I also understand that, under the law and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others. I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

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

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William Arndt, MA, LMFT, LCADC \_\_\_\_\_ Date \_\_\_\_\_