Elizabeth Ritzman, LCPC
6832 West North Avenue, Suite 4B Chicago, IL 60707
Consent to Telehealth Services

This form gives informed consent for the use of video technology for online or phone therapy and/or health care. Read it thoroughly for understanding and ensure all of your questions are answered before signing. This is to be used in conjunction with, but does not replace the Information and Consent to Treat.

Technology I understand that visits conducted online are technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the provider/counselor who makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call me at 312-815-9607.

Confidentiality I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I understand that there will be no recording of any of the online session either audio, video or still images. I agree that all information disclosed within sessions and the written records pertaining to those sessions are confidential except where disclosure is permitted by conditions listed in Consent Statement.

Emergency-Counseling In order to ensure safety, I will confirm my current location (address) at the time of the online counseling appointment. I will also provide an emergency contact person and phone number. If I experience a mental health emergency, I will call 911.

Consent to Treatment I, voluntarily agree to receive online counseling or healthcare sessions for intake, continued care, treatment, or other services and authorize Elizabeth Ritzman LCPC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services at any time. I agree to remain within Illinois while receiving these counseling services. ***In signing this Informed Consent by typing my name or in ink, I acknowledge that I have both read and understood all the terms and information contained herein. Opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.***

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____

Date: _____