



PURA VIDA HEALTHCARE
Your Mind-Body Connection

Thriving: Therapy & Yoga

Shelley L Nielsen, LCSW & RYT200
160 E 12th Street, Ste. 1, Durango, CO 81301
Phone: (970) 946-1383
Email: shelleynielsen@gmail.com
www.thrivingtherapyyoga.com

Informed Consent for Online/Telehealth Therapy

I (Client name) _____
agree and give consent for psychotherapy and treatment by Shelley Nielsen, LCSW using an Internet based platform/software. I understand that the platform/software is considered secure and encrypted and meets HIPAA standards of use. I understand that there are certain risks involved in entering into this therapeutic relationship and that those risks have been explained to me.

I understand that online counseling services include, but are not limited to, consultation and treatment using interactive audio, video, and/or data communications. I understand that online counseling services involve the communication of my medical/mental health information to the above referenced provider. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I understand that the laws that protect the confidentiality of my medical information also apply to online counseling services. I understand that the dissemination of any information is under the same HIPAA standards as traditional therapy.

Although rare, I understand that there are risks to Internet based services including, not limited to, the possibility, despite reasonable efforts on the part of the online platform being used and/or Therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

By participating in online therapy services I am aware of potential benefits and risks. Some benefits may include improved access to services, being able to choose the therapist I want with specialty experience, the convenience of not having to travel to a therapist and using whatever means of communication I am comfortable with. Although risks are rare, I am aware there are possible risks which include that the information I am

970.426.1684 (office) 1.970.797.1544 (fax) www.puravidahealthcare.com
160 E. 12th Street, Suite 1, Durango, CO 81301

able to give may not be sufficient to allow for a diagnosis, that there may be delay in response from my therapist due to technical failures or unforeseen events, and that I may not be able to respond to my therapist due to my own technology failures or unforeseen events. I understand that my therapist may not be able to provide certain services to me.

Informed consent continues throughout the course of therapy and my therapist will continue to talk with me about risks, benefits or educate me on the process of therapy as we go along. I agree to pay the stated cost for services, and understand that there are no refunds for services rendered.

By signing below, we have read, understood and agreed to the Statement of Informed Consent for Online Counseling/Telehealth:

Client: _____ Date _____

Counselor/Therapist _____ Date _____