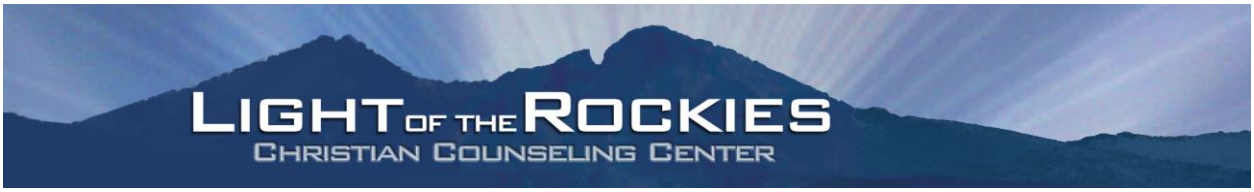

Tele-Therapy and Electronic Therapy (E-Therapy) Informed Consent Form

I, _____, hereby consent to engaging in tele-therapy and/or electronic therapy with Light of the Rockies Counseling Center, as part of my mental health treatment. I understand that "tele-therapy" and "electronic therapy" includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications such as the telephone, cellular phones, the internet, and various programs such as iChat, SKYPE, AIM, and Face Time. I understand that if I am experiencing an emergency, seriously considering harming myself/suicide, or considering harming someone else that I should immediately go to the hospital or call 911 for help.

I understand that I have the following rights with respect to tele-therapy and/or electronic therapy:

(1) 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 program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my health information also apply to tele-therapy and electronic therapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the tele-therapy and/or electronic therapy interaction to other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from tele-therapy and electronic therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my health information could be disrupted or distorted by technical failures; the transmission of my health information could be interrupted by

unauthorized persons; and/or the electronic storage of my health information could be accessed by unauthorized persons. I also understand that the programs listed above have their own policies that might interfere with confidentiality and I am fully aware of the risks associated with working with these programs. In addition, I understand that tele-therapy and electronic therapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychological services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area.

(4) I understand that I have a right to access my health information and copies of records in accordance with state law.

I have read and understand the information provided above. I have discussed it with my therapist, and any of my questions have been answered to my satisfaction.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date