CAITLIN R. BURGESS, JD, MA, LMFT
Professional Clinical, Legal, and Forensic Services

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TELEHEALTH WAIVER

I authorize Caitlin R. Burgess, JD, LMFT, and any of her clinical associates to perform telehealth services using telecommunications programs for myself and/or my minor child(ren).

I confirm that Caitlin R. Burgess, JD, LMFT, and any of her clinical associates can reach me and/or my minor child(ren) with video calls or audio calls as part of the online sessions.

I acknowledge that in this type of platform technical difficulties may happen which might cause a slight delay or might need rescheduling. I also acknowledge that use of telehealth services, including email, have some inherent risks to confidentiality, and by signing this informed consent agreement, I understand and accept those risks.

I accept that I can withdraw this waiver any time and it will not affect my situation when I need care in the future.

I confirm that telehealth services require the collection of personal information and that I have read and understand the above.

Acknowledgment: By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed the terms and conditions with Therapist, and any questions have been answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in telehealth sessions with Therapist.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____