CHRISTIAN LIFE COUNSELING

TELEMENTAL HEALTH SERVICES INFORMED CONSENT

I, _____, agree to participate in teletherapy with a mental health provider at Christian Life Counseling.

This means that:

● I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection utilizing Zoom Video Communications, Inc., and or other HIPPA Compliant Telehealth Company.

● I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.

● My provider has explained how the teletherapy system works and how it will be used for my treatment.

● My provider has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.

● I understand that my provider will not be physically present during my teletherapy session. Instead, we will see each other electronically.

● I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized.

● Potential risks include: a) at times the video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.

● I authorize the release of information pertaining to me determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.

● I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My provider will refer me to a local mental health provider who can provide face-to-face services.

● I agree to take every precaution to preserve the confidentiality of my sessions, such as ensuring that calls are taken in a safe and secure location to the extent possible.

● I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are

dangerous to myself or others or are suspicions of child or elder abuse.

● My provider has explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in-person.

● I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.

The contact information for my provider is:

● Name:

● Email:

● Phone:

These are the names and phone numbers of my local emergency contacts:

● Primary care physician:

● Third Party Individual:

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Name: Date:

Parent or Legal Guardian: Date