

## 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