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Addiction Professional 1243
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Telemental Health Policy and Consent

I/We, ______________________________________, hereby consent to participate in telemental health with Sally Erickson, MA, CAP, LMHC, as part of my/our counseling/ psychotherapy. I understand that telemental health involves the delivery of clinical counseling services, where the practitioner and the client(s) are in different locations. Whenever possible, services will be delivered via an encrypted HIPAA compliant video media or other electronic means.

I/We also understand the following with respect to elemental health:

1. I/We understand that I/we have the right to withdraw consent at any time.

2. I/We understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I/We understand that there will be no recording of any of the online sessions by either party without expressed consent. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I/We understand that the privacy laws that protect the confidentiality of protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health crisis as an issue in a legal proceeding.)

5. I/We understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6. I/We understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, please log-off and then log-on again. If we are unable to reconnect within ten minutes, please call

me at 407-331-7911 as we may have to reschedule.

7. I/We understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session if your location is other than your usual location/address (listed below). I also need a person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My usual location is:

____and my emergency

contact person's name, address, phone:______________________________

____

Print name of client: Date:

____________________________________ ________________

Signature of client: Date:

____________________________________ ________________

Signature of therapist Date:

____________________________________ ________________