TPC
Integrative Psychotherapy & Pastoral Counseling

TELEHEALTH CONSENT

Purpose: The purpose of this form is to obtain your consent to participate in a telemedicine psychotherapy session with a therapist at Triangle Pastoral Counseling.

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider

A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time.

I, *(Client Name)* _____, consent to engaging in telehealth with Triangle Pastoral Counseling, Inc. as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Triangle Pastoral Counseling, Inc that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

4. In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to such services. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

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5. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Secure Video technology may have issues with WiFi connectivity.

6. I understand that I have the right to access my personal information and copies of clinical notes. I have read and understand the information provided in this document. I have had the opportunity to discuss these points with my therapist, and all my questions regarding the named matters have been answered.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situations may include but are not limited to thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, suicidal thoughts, active drug or alcohol abuse or other life-threatening conditions. I agree that I will not record this private session by any means.

Client Signature: _____ Date: _____

Client Name (Printed): _____

Client Representative: _____ Date: _____

Witness: _____ Date: _____

Provider: _____

Location: _____