04.2020

Client Consent - Internet or Telephone Counseling

I hereby consent to engaging in internet and/or telephone counseling with The Center for Integrative Counseling and Psychology. I understand that these modes of service include the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of health care data, and I understand that internet and/or telephone counseling also may involve the communication of my mental health/health information, both orally and visually. I understand that encrypted phone lines are likely not used and therefore confidentiality cannot be guaranteed if sessions are conducted in areas with unsecure internet access (public WIFI). In addition, it is recommended that phone sessions occur in areas where you can assure privacy and not while running errands or in public areas. The clinician cannot assure confidentiality of information on the clients end (use of public WIFI, unsecure networks, speaking in public areas, etc.). In consenting to telecounseling I am agreeing to HIPAA compliant confidentiality and I will not capture any photos, video, or audio recordings of sessions.

I understand that I have the following rights with respect to internet and/or telephone counseling:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my health care information also apply to internet and/or telephone counseling. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
   I also understand that the dissemination of any personally identifiable images or information from the internet and/or telephone counseling interaction to researchers or other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from internet and/or telephone counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my health care information could be interrupted by unauthorized persons; and/or the electronic storage of my health care information could be accessed by unauthorized persons.
   In addition, I understand that internet and/or telephone counseling-based services and care may or may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.
4. I understand that I may benefit from internet and/or telephone counseling, but that results cannot be guaranteed or assured.

My signature below indicates that I understand the type and scope of information being disclosed as well as the risks associated with internet and telephone counseling, I have been offered the opportunity to ask questions regarding the use of this information, and I consent to internet and telephone counseling.

Client Printed Name: _____ Client Signature: _____ Date: _____

Or for Minor

Parent/Guardian Printed Name: _____ Parent/Guardian Signature:_____ Date: _____

I have legal authority to sign this on behalf of _____ Relationship: _____
(Name of Minor)