TELEMENTAL HEALTH INFORMED CONSENT

I, _____, hereby consent to participate in telemental health with Caryn Lindner, LCSW, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to disruption of transmission by technology failures, possible interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. 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 understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (mandatory reporting of a child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or 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 understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. This may be resolved by switching to a different method, such as the telephone, if the video is not working properly, or vice versa.
7. I understand that my therapist may need to contact my emergency contact and/or the 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. I also need a contact 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 emergency contact person's name, address and phone is:_____

_____

I have read the information on the previous page and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____	_____
Signature of client	Date
_____	_____
Signature of therapist	Date