Wholistic Therapeutic Services, LLC

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Informed Consent for Telemental Health Services

I hereby consent to engaging in Telemental Health (herein referred to as "distance therapy") with Alexia M. Tanner, LCSW and parties associated with Wholistic Therapeutic Services, LLC, as part of my psychotherapy. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance therapy:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to distance therapy. As such, I understand that the information disclosed by me during the course of my therapy 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 telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand that there are risks and consequences from distance therapy, 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 medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPPA-compliant service which is encrypted for video Telemental Health communications. Further, the contents of my therapist's computer are encrypted.
- I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services, group therapy), I will be referred to a psychotherapist who can provide such services in my area.
- I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.
- I also understand that I must provide a reliable emergency contact (to remain on file) that would be able to have access to me in the event of an emergency. I understand that in the event the therapist has reasonable and professional concern that I may be a harm to myself or others, emergency services (including provided contact) will be contacted and my last known address will be disclosed. I understand that I have the right to remove the emergency contact at any time in writing but must disclose a new emergency contact for therapeutic services to continue.

- My Emergency contact is:

  _____

  _____

  Name, Address and Telephone Number must be included.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

Client Signature Date

_____ _____

Parent or Guardian Responsible for Client Date:

_____ _____

Therapist's Signature Date

_____ _____

Therapist Supervisor's Signature Date

_____ _____