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Online Practice Only Psychology Today Information: Zip Code 14456

INFORMATION AND CONSENT FOR ASSESSMENT AND TREATMENT -- TELEHEALTH

Name: _____ Date of Birth: _____

Phone # to use in case of service disruption: _____

I hereby consent to engaging in telehealth with my therapist, Joseph P. Carlino, LCSW. I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision-making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Telehealth psychotherapy will occur primarily through interactive audio, video, and/or telephone.

I understand the following with respect to telehealth:

1. All information in the Outpatient Services Contract, signed separately, applies to my telehealth treatment.
2. I have the right to withhold or withdraw consent at any time.
3. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. There are specific and limited exceptions to confidentiality, which are outlined in the Outpatient Services Contract signed separately. 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.
4. I understand that my therapist utilizes a secure video platform that is HIPAA compliant.
5. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional who can provide such services.
6. I understand that there are potential risks and benefits associated with any form of counseling and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases, may even get worse. I understand that I may benefit from telehealth psychotherapy, but that results cannot be guaranteed or assured.

If I am in crisis or in an emergency, I should immediately call 911 or I should go to the nearest hospital's emergency services. I understand that emergency situations include if I have thought about hurting or killing either another person or myself, or if I am in a life-threatening or emergency situation of any kind.

I have read and understand the information provided above. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based therapy services.

Client Signature: _____ Date: _____