PROMISEPLACE
SEXUAL ASSAULT RESOURCE CENTER
where hope and healing begin

1401 Park Avenue, New Bern, NC 28560
Phone 252-636-3381

Fax 252-636-2278

115 S. Market Street, Trenton, NC 28585
Phone 252-448-1069

11097 Highway 55, Grantsboro, NC 28529
Phone 252-745-9439

271 Hamilton Drive, New Bern, NC 28560
Phone 252-633-6197

TELEMENTAL HEALTH CONSENT FORM

Client Name _____ Date of Birth _____/_____/_____ Client ID _____

I _____, (name of client) hereby consent to participate in telemental health as part of my psychotherapy with _____ (name of provider) at Promise Place. 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 via the Withdrawal of Consent Form being provided to me today. I may withdraw my consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

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Client Name _____ Date of Birth _____/_____/_____ Client ID _____

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 (i.e. mandatory reporting of 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. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or 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 located 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.

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TELEMENTAL HEALTH CONSENT FORM

Client Name _____ Date of Birth _____/_____/_____ Client ID _____

In case of an emergency, my emergency contact person is:

Name: _____

Address: _____

Phone: _____

I have read the information provided above 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.

_____

Client Signature Date

_____

Parent/Legal Guardian Signature Date

_____

Therapist Signature Date

The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. Nothing reported herein should be used as a substitute for the advice of competent counsel.

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WITHDRAWAL of TELEMENTAL HEALTH CONSENT

Client Name _____ Date of Birth _____/_____/_____ Client ID _____

I _____, (name of client) hereby withdraw consent to participate in telemental health as part of my psychotherapy with _____ (name of provider) at Promise Place. I understand that this withdrawal of consent does not impact the receipt of any other services provided to me by Promise Place. I also understand that I have the right to resume telemental health services at any time in the future by signing a new Telemental Health Consent Form.

_____

Client Signature Date

_____

Parent/Legal Guardian Signature Date

_____

Therapist Signature Date

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