ASH POINT COUNSELING

# *Telecounseling Informed Consent*

Client Name:_____ Date of Birth:_____

Location of Client: _____

**Introduction:**

Telecounseling or teletherapy is the delivery of counseling or therapy services using interactive video conferencing. Telecounseling enables a therapy provider at a distant location to provide consultation, assessment, and treatment to me. I understand that this consultation will not be the same as direct client/therapist visit. Telecounseling will allow me to receive outpatient therapy without the need to visit the office and travel long distances. **In the event interactive video conferencing is unavailable telephonic services may be utilized via telephone communication.**

**During the telecounseling consultation:**

- Details of my mental health history, medical history, and current psychological symptoms will be discussed.
- No other person will be present in the office of the telecounseling provider.

**Expected Benefits:**

- Improved access to outpatient therapy by enabling a client to remain in their home, a local office, or a confidential setting of their choice.
- More efficient mental health evaluation and management.
- Obtaining expertise of a distant specialist.

**Possible Risks:**

As with any provision of mental health services, there are potential risks associated with the use of telecounseling. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images, poor phone reception) to allow for appropriate decision making or treatment by the mental health provider;
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In rare cases, security protocols could fail, causing a breach of privacy of personal medical information;

**Alternatives to the use of telecounseling:**

- Traditional face to face sessions are always available in the office: I understand that as part of my benefits MaineCare will pay for my transportation to and from these traditional face to face counseling sessions.

Please initial after reading this page: _____

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**My Rights:**

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telecounseling.
- I have the right to withhold or withdraw my consent to the use of telecounseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment and will not risk the loss or withdrawal of my MaineCare benefit.
- I understand that **Ash Point Counseling LLC** has the right to withhold or withdraw consent for the use of telecounseling during the course of my care at any time.
- I understand that the all rules and regulations which apply to the practice of therapy/counseling in the state of Maine also apply to telecounseling.

**My Responsibilities:**

- I will engage in an in-person initial intake session with **Ash Point Counseling LLC** if I am fully vaccinated and feeling well barring additional health and safety circumstances or unvaccinated status.
- I will not record any telecounseling sessions without written consent from **Ash Point Counseling LLC**. I understand that **Ash Point Counseling LLC** will not record any of our telecounseling sessions without my written consent.
- I will inform **Ash Point Counseling LLC** if any other person can hear or see any part of our session before the session begins. **Ash Point Counseling LLC** will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not **Ash Point Counseling LLC**, am responsible for the configuration of any electronic equipment used on my computer for telecounseling. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be a resident of the state of Maine to be eligible for telecounseling services from **Ash Point Counseling LLC**.

**Client consent for the use of Telecounseling:**

I_____ have read and understand the information provided above regarding telecounseling, have discussed it with **Ash Point Counseling LLC**, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telecounseling in my mental health care and authorize **Ash Point Counseling LLC**, to use telecounseling in the course of my diagnosis and treatment. If for any reason/s, telecounseling will not work for my treatment, then I will come to the office for ongoing evaluation and treatments.

Signature of Client:_____ Date:_____

Legally Authorized Representative/Guardian:_____ Date:_____

Relationship:_____

Witness:_____ Date:_____