# Amy Grassi Watson, LCMHC-S
# Tele-counseling Informed Consent

Client Name: _____ DOB: _____

Location of Client: _____

## Introduction:

Tele-counseling or tele-therapy is the delivery of counseling or therapy services using interactive video conferencing. Tele-counseling 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. Tele-counseling will allow me to receive outpatient therapy without the need to visit the office and travel. In the event interactive video conferencing is unavailable, telephonic services may be utilized via telephone communication.

## During the tele-counseling consultation:

- Details of my mental health history, medical history, and current psychological symptoms will be discussed
- Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
- I will be informed about who is present in the office.

## Possible Risks:

As with any medical procedure, there are potential risks associated with the use of tele-counseling. These risks include:

- In rare cases, information transmitter may not be sufficient (e.g. poor resolution or images, poor phone reception) to allow for appropriate decision making or treatment by the mental health provider
- Security protocols could fail, causing a breach of privacy of personal medical information
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment
- In rare cases, a lack of access to complete mental health records may result in adverse treatment reactions or judgment errors

## My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to tele-counseling.
- I have the right to withhold or withdraw my consent to the use of tele-counseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that Amy Grassi Watson has the right to withhold or withdraw consent for the use of tele-counseling during the course of my care at any time.
- I understand that all rules and regulations which apply to the practice of therapy/counseling in the state of NC also apply to tele-counseling.

My Responsibilities:

- I will not record any tele-counseling sessions without written consent from Amy Grassi Watson. I understand that Amy Grassi Watson will not record any of our tele-counseling sessions without my written consent.
- I will inform Amy Grassi Watson if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Amy Grassi Watson, am responsible for the configuration of any electronic equipment used on my computer for tele-counseling. 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 NC to be eligible for tele-counseling services from Amy Grassi Watson.
- I understand that during my initial evaluation by Amy Grassi Watson, I will be required to provide photo identification to verify my identity to provider's satisfaction at the evaluation.

Client Consent for the use of Tele-counseling:

I _____ have read and understand the information provided above regarding tele-counseling, have discussed it with Amy Grassi Watson, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-counseling in my mental health care and authorize Amy Grassi Watson to use tele-counseling in the course of my diagnosis and treatment. If for any reason(s), tele-counseling will not work for my treatment, then I will need to come to the office for ongoing evaluation and treatments.

Signature of Client: _____ Date: _____

Legally Authorized Rep/Guardian: _____ Date: _____

Relationship: _____

Witness: _____ Date: _____

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