Albemarle Counseling Group
1129 Horseshoe Rd.
Elizabeth City, NC 27909
(252)-335-2018 ext. 226

Telemental Health Informed Consent Addendum

Date: _____ Therapist: _____

Client Name: _____ Date of Birth: _____

Insurance: _____

I hereby consent to engaging in telemental health services (counseling/psychotherapy) as part of my psychotherapy. I understand that telemental health 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 this while this addendum specifically covers telemental health, all other consent to treat, financial agreements, and informed consent documents still apply to all of my treatment.

_____I understand that my therapist is licensed in the state of North Carolina, and that I will only participate in telemental health sessions while both my therapist and I am physically located in that state. I agree to participate in sessions in a location which is confidential and allows for 60 minutes of uninterrupted telemental health services.

_____I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

_____The laws that protect the confidentiality of my medical information also apply to distance counseling. As such, I understand that the in
formation 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 telemental health, 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 HIPAA-compliant service which is encrypted for video telemental health communications. Further, the electronic record is encrypted and secured.

_____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 have read and understand the information provided above. I have been given the opportunity to review this information with my therapist, and have had the opportunity to ask any questions regarding the delivery of telemental health services.

_____In the event of emergency, I understand that during business hours, I may contact my therapist at (252)-335-2018 and let the receptionist know that it is an emergency. I also understand and agree to utilize the Albemarle Counseling Group's Answering Service to reach my therapist during an emergency at (757)-490-4117 after business hours. I agree to contact my therapist by telephone (not by email or other electronic communication) or other local resources in the event of an emergency. I also understand that I may access care in an emergency by dialing 911 or going to my nearest emergency room. I understand that there may also be other local resources available.

_____ I consent for the therapist to e.g., utilize the following email address to contact me. I consent for the email to contain my therapist's name and/or business name: _____.

_____Resources identified in my area for crisis/emergency mental health services include:

Integrated Family Services
Mobile Crisis Team:1-866-437-1821

PORT Health and Human Services: 252-335-0808

Emergency Services: 911

_____
Patient/Guardian Signature Date

_____
Print Patient Name

_____
Therapist Signature Date

_____**Copy given to patient**