**STARFISH EXPERIENCE INCORPORATED**

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**Telemental Health Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to participate in

Telemental health with, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as part of my

Psychotherapy. 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 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, benefits, 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.

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 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.

In case of an emergency, my location is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and my emergency contact person’s 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Parent/Guardian Date

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Signature of Therapist Date