Telecounseling Consent Form

Client Name:_____Date of Birth:_____State of Residence:_____

Telecounseling or teletherapy is the delivery of counseling or therapy services using interactive video conferencing. Telecounseling will allow me to receive outpatient therapy without the need to visit the office and travel long distances.

Expected Benefits:

- Improved access to outpatient therapy by enabling a client to remain in his/her home or their primary care provider's office.
- More efficient mental health evaluation and management.

Possible Risks:

- 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;
- Security protocols could fail, causing a breach of privacy of personal medical information.

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.
- I understand that Anne Dadura 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 inform Anne Dadura if any other person can hear or see any part of our session before the session begins. Anne Dadura 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 Anne Dadura, am responsible for the configuration of any electronic equipment used on my computer for telecounseling.

Client consent for the use of Telecounseling:

I_____have read and understand the information provided above regarding telecounseling. I hereby give my informed consent for the use of telecounseling in my mental health care and authorize Anne Dadura, to use telecounseling in the course of my treatment. If for any reason/s, telecounseling will not work for my treatment, then I will need to come to the office for ongoing treatment.

Signature of Client:_____Date:_____

Legally Authorized Representative/Guardian:_____Date:_____

Witness:_____Date:_____