Total Life Counseling, Inc.

5401 Fallowater Lane, Suite C, Roanoke, VA 24018

Informed Consent for Online Counseling Teletherapy

I hereby consent to engaging in online counseling services with the psychotherapist(s) I have selected through Total Life Counseling, Inc. I understand that online counseling services include, but are not limited to, consultation, treatment, and using interactive audio, video, or data communications. I understand that online counseling services involve the communication of my medical/mental information, both orally and visually, to health care practitioners that may be located outside my local area or state.

I understand that I have the following rights with respect to online counseling services:

1. *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.*
2. *The laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information 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.*
3. *I also understand that the dissemination of any personally identifiable images or information from the online counseling services to researchers or other entities shall not occur without my written consent.*
4. *I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, 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.*
5. *In addition, I understand that online counseling services may not be as complete as face-to-face services. I also understand that if the counselor believes I would be better served by another form of counseling services (e.g. face-to-face services) I may be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling services, and that despite my efforts and the efforts of the counselor, my condition may not be improve, and in some cases may even get worse.*
6. *I understand that I may benefit from online counseling services, but that results cannot be guaranteed or assured.*
7. *I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.*

I have read and understand the information provided above and give my consent for Teletherapy treatment.

Client Name (Print)_____

Signed_____ Parent/Guardian _____ Date_____
(if client is under 18 years old)

Once this form is completed, please send to totallifecounseling@yahoo.com