

**Erica N. Green, LCSW**  
**Clinical Social Worker**  
*Telecounseling Informed Consent*

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Introduction:**

Telecounseling services use technology to allow a health care provider to provide services to a client who is at a different location. For counseling, videoconferencing would be used, with equipment and software that allows you and your provider to see and hear each other at the same time, very much as though you were sitting together in the same office. These services can be provided in the event that ongoing face-to-face sessions cannot continue, such as sickness. My practice is a face-to-face practice, however, telecounseling can be used, and will be discussed and used on an as-needed basis.

Telecounseling may not be medically appropriate in some situations. If this is the case, we will discuss it. If medically appropriate, Telecounseling services will not differ from the same services provided in person except for the means of communication. Telecounseling services are subject to the same state and federal confidentiality requirements that apply to services provided in person. The equipment and software used for Telecounseling will meet all applicable state and federal privacy and security standards. You may have access to all information resulting from Telecounseling services as provided under state and federal law.

**During the telecounseling consultation:**

- As in an in-person session, details of my mental health history, medical history, and current psychological symptoms will be discussed.

**Expected Benefits:**

- Opportunity to continue treatment in the event that face-to-face visits are unable to occur
- Increased access, not requiring office visits, on a short-term basis

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telecounseling. These risks include, but may not be limited to:

- Risk of poor images; poor sound quality, inefficient Internet speed and connection, which may lead to poor or less effective communication or treatment.
- As with any means of communication between different locations, there is always a small but unavoidable risk that security protocols could fail, causing a breach of privacy of personal medical information
- You may not be comfortable with the means of communication, and therefore it could be less effective
- You and I may not be able to observe and communicate with each other as well as in a face-to-face meeting, so that some elements of communication might be less effective.

**Alternatives to the use of telecounseling:**

- Traditional face-to-face sessions in office.

**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 and will not risk the loss or withdrawal of my health insurance benefit.
- I understand that Erica N. Green, LCSW 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 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 not record any telecounseling sessions without written consent from Erica N. Green, LCSW. I understand that Erica N. Green, LCSW will not record any of our telecounseling sessions without my written consent.
- I will inform Erica N. Green, LCSW if any other person can hear or see any part of our session before the session begins. Erica N. Green, LCSW 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 Erica N. Green, LCSW am responsible for the configuration of any electronic equipment used on my computer for telecounseling. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that if I have not checked-in within 15 minutes of the scheduled time of my appointment it will be considered a no-show and I may be expected to pay a no-show fee. I understand that I, not Erica N. Green, LCSW, am responsible for my attendance.
- I understand that I must be a resident of and physically in the state of Maine at the time of my appointment to be eligible for telecounseling services from Erica N. Green, LCSW.
- I understand that I (not my insurance company) am responsible for full payment of my fees. I understand that it is my responsibility (not Erica N. Green, LCSW) to confirm my telehealth/telecounseling benefits with my insurance company.

**Client consent for the use of Telecounseling:**

I \_\_\_\_\_ have read and understand the information provided above regarding telecounseling, have discussed it with Erica N. Green, LCSW and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telecounseling in my mental health care and authorize Erica N. Green, LCSW to use telecounseling in the course of my diagnosis and treatment. If for any reason/s, telecounseling 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 Representative/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_