SUMMIT COUNSELING
Sarah West-Effland LCSW, LLC, Owner of Summit Counseling
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Informed Consent for Telemental Health or Telephone Services

I understand that telemental health therapy is not crisis treatment and that if I am in need of immediate medical or mental health attention, I should call 911, go to the closest ER, or call the crisis hotline 1-800-273-8255.

I understand that with the use of telemental health services, even HIPPA compliant formats, there is a risk of security breaches. I understand that my provider will first attempt to use a HIPPA compliant format, if a technical issue arises that does not allow this, my provider may request we try another format and will discuss the risks of using a non-HIPPA compliant format if needed. If there is a concern, the session can be scheduled for a later date when the technical issues have been resolved.

I understand that during a telemental health session, both locations (client and clinicians) are considered treatment rooms. Both parties need appropriate audio and visual equipment for privacy. I understand that permission is required for either party to record the session. All HIPPA requirements apply to the session except when client consent has been granted for possible breach of HIPPA violation.

I understand that it is important for me to have privacy and to limit distractions that would cause difficulty for productivity to occur during therapy. I also understand that I will tell the clinician, prior to the session, if anyone else is in the room. If the clinician determines that it is not going to allow a productive session, he/she may request that you reschedule.

I understand that my clinician may determine that telemental health is not the best treatment option in my case and may discuss in-person treatment. If needed my clinician will refer me to a provider closer to my physical location.

I understand that my current health insurance may not cover telemental health services, and I may be responsible for any charges that are due to this. I consent for Summit Counseling to send required documentation for billing purposes.

I understand that a 24-hour cancellation policy is required for telemental health services.

Client Signature: _____ Date: _____

Print the name of Parent or Legal Guardian if the above client is a minor: _____

Your relationship to the client as the person signing for him/her: _____

Parent or Legal Guardian Signature: _____ Date: _____

For filling out this form electronically: Just type your name into the signature field(s) above to sign the form.