**TELE-MENTAL HEALTH INFORMED CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to participate in tele-mental health sessions with, **Dr. Elanah Naftali.** I understand that tele-mental 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 tele-mental health**:

1)- 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)- There are risks, benefits, and consequences associated with tele-mental 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)- There will be no recording of any of 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)- The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental 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)- 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 tele-mental health services are not appropriate and a higher level of care is required.

6)- I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions.

7)- I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**EMERGENCY PROCEDURES:**

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 whom 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**My emergency contact’s name, address, phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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• **I have read and discussed the above information, as needed, with my therapist; my HIPAA privacy rights were explained and any questions answered to my satisfaction.**

**• I understand that I am voluntarily entering this therapeutic alliance and can terminate it at any time. I agree to give, Elanah Naftali, advanced notice of my intention to end services. I agree to a closing session to settle any unfinished business or session content (usual fee may be negotiable, if requested in advance.).**

* **I agree to pay \_\_\_\_\_\_ /hour-long session, at the time of my scheduled appointment.**

**Payment is due at time of visit; digital payments are made in Venmo.**

**• I request a 24-hour cancellation notice, or a $75 late-cancel fee will be charged for any missed appointment with insufficient notice. The fee is waived altogether, if the appointment can be rescheduled within the same week.**

* **Emailing and texting will be used to schedule, confirm, or cancel appointments.**

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**Printed Name(s) / Client Signature(s) (or Parent/Legal Guardian) Date**