Advanced Counseling and Testing Solutions, LLC

2121 Oregon Pike, Suite 201
Lancaster, PA 17601
T: 717-208-6599 F: 717-208-7753
www.ACTSofLancaster.com

4 Wellington Blvd.,Suite 101
Wyomissing, PA 19610
T: 484-987-7116 F: 717-208-7753
www.ACTSofReading.com

Teletherapy Informed Consent

I,_____, hereby consent to engage in teletherapy with **Advanced Counseling and Testing Solutions, LLC**.

I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually. I understand that I have the following rights with respect to teletherapy:

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

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call **717-208-6599 (option 1 -Lancaster or option 2 for Wyomissing)** to discuss since we may have to reschedule.

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

Helping clients is our mission, not only our profession!

Advanced Counseling and Testing Solutions, LLC

2121 Oregon Pike, Suite 201
Lancaster, PA 17601
T: 717-208-6599 F: 717-208-7753
www.ACTSofLancaster.com

4 Wellington Blvd.,Suite 101
Wyomissing, PA 19610
T: 484-987-7116 F: 717-208-7753
www.ACTSofReading.com

Emergency Protocols

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 who 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: _____ and

my emergency contact person's name, address, phone:

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Client or Guardian Signature Date

_____

Client Printed Name

Helping clients is our mission, not only our profession!