Lindsay Martin, PhD, LPC, NCC

Licensed Professional Counselor

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Tele-Mental Health Informed Consent

I hereby consent to participating in telemental health services with Dr. Lindsay Martin for psychotherapy. I understand that telemental 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 telemental health:

- 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.
- I understand 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.
- I understand 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.
- 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).
- 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.
- I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, please end the call and restart the session. If we are unable to reconnect within ten minutes, please call me at # 484-424-9202 to discuss as we may have to re-schedule.
- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be directed to emergency 911 services in my community.

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

Emergency Protocol

- As your therapist, 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.

Please name your emergency contact person here and provide their address and phone number:

_____ _____
Emergency Contact Name Emergency Contact Phone Number

_____
Address of Emergency Contact

I certify that I have read and understand this agreement and have the right to have questions answered to my satisfaction. I hereby acknowledge and accept the terms outlined above:

Print name here: _____

_____ _____
Client Signature Date

For Minors or those requiring Guardianship

On behalf of _____, my minor child or person entrusted to me for guardianship, I agree to the above policies and give permission for Lindsay Martin, Ph.D. to provide treatment.

Print name here: _____

_____ _____
Parent/Guardian Signature Date

Print name here: _____

_____ _____
Parent/Guardian Signature Date