TRANSITIONS
COUNSELING SERVICES, INC

Telemental Health Informed Consent Form

I_____ hereby consent to engaging in telemental health with the therapist of Transitions Counseling Services, Inc listed below as part of my psychotherapy. I understand that "Telemental Health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telemental health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self, and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies.

In addition, I understand that telemental health-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

(4) I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with Massachusetts law.

(6) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in the event of an emergency. I understand it is my responsibility to also seek appropriate emergency services such as 911 and/or local crisis services (i.e. Riverside Community Care, Milford and surrounding communities 800-294-4665) if I am experiencing a mental health crisis. I agree to inform my therapist of the address where I am located at the time of session.

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

_____	_____	_____
Signature of Patient/Parent/Guardian	Date	If signed by other than patient indicate relationship
_____		_____
Printed Name of Therapist		Signature of Therapist, License, License #

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