



Consent for Telemental Health Services

1. I understand that the counseling staff of Crossroads Counseling Center are available for Telemental Health Services (TMH).
2. I understand that TMH provides counseling and support over the internet through email, video conferencing, online chat, FaceTime, and/or phone calls between a client and a counselor who are not in the same physical location.
3. I understand that TMH services offers benefits including easier access, the convenience of meeting from a location of my choosing, a continuity of services during public health emergencies and/ or other life circumstances.
4. I understand there are potential risks to this technology including interruptions and technical difficulties.
5. I understand that if a session is disrupted, I can reach my counselor via phone and/ or email. My counselor or I can choose to discontinue the TMH session if either believes the videoconferencing or phone connections are not adequate for the situation.
6. I understand that in the event of an emergency/ crisis during or between TMH sessions, I may contact 911.
7. I understand that certain information will be verified at the start of each TMH session in order to confirm privacy and safety: the names of all those in the session, the location of the client and phone contact information in case of disrupted technology.
8. I understand that no session may be audio or video recorded by either the counselor or myself without express written consent from both parties.
9. I understand that I am responsible for creating a safe and confidential space during my TMH sessions. I understand that I can ask my counselor for assistance if I am not sure how to create this safe and confidential space.
10. I understand that together with my counselor we will regularly assess the appropriateness of TMH services. Any practical alternatives and modifications will be made as needed.
11. I understand that if I am the parent/ guardian of a minor child receiving TMH services, I will be on the same premises as the minor child and will be available by phone if needed during the entire session.



12. My signature below indicates I have read and understand all of the above information and am aware I have the opportunity to ask questions regarding the procedures and details of TMH services.
13. If I am the parent/ guardian of a minor child, my signature below also indicates I consent for the minor child to receive TMH services. Additionally, the child is willing to engage in these services.
14. I understand that if a minor child or a client is unwilling to engage in the scheduled counseling session, the Cancellation Policy is still in effect (refer to the Crossroads Counseling Center Agreement).
15. I understand that in the case of joint physical and/or legal custody, consent is required from both parents as indicated by signatures below.

Client Name (printed) _____

Client Signature _____

Date: _____

Parent/ Guardian Name (printed) _____

Parent/ Guardian Signature _____

Date: _____

Parent/ Guardian Name (printed) _____

Parent/ Guardian Signature _____

Date: _____

Counselor Name (printed) _____

Counselor Signature _____

Date: _____

Counseling for Minors (AGE 17 & UNDER) Session Phone Contact Information:

Parent/ Guardian Name _____ Relationship to Child _____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent/ Guardian Name _____ Relationship to Child _____

Home Phone _____ Cell Phone _____ Work Phone _____

