

Jan Waters, LPC, RPT, LLC

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NJ Lic. No.: 37PC00383100

Tax ID: 82-4970839

NPI: 1528394616

Informed Consent for TeleMental Health Services

I hereby consent to engage in distance counseling with *Jan Waters, LPC* as part of my psychotherapy. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance counseling:

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.

The laws that protect the confidentiality of my medical information also apply to distance counseling. 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 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 telemedicine interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from distance counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of HIPAA-compliant service that is encrypted for video TeleMental Health communications.

I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face therapy), every effort will be made to refer me to a psychotherapist who can provide such services. I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.

Considerations:

It is important to note that there are limitations of distance counseling that affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during face-to-face session.

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

Client Signature

Date

Therapist Signature

Date