TELEHEALTH INFORMED CONSENT

Client Name (please print last name, first name) Address

I, ◯ client OR ◯ parent/guardian of client named _____, date of birth _____ hereby consent to engage in telehealth for grief counseling/bereavement support. I understand that "telehealth" includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. I understand telemedicine also involves the communication of my medical/mental health information, both orally and visually.

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS WITH RESPECT TO TELEMEDICINE:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my participation in grief counseling/bereavement support is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, as discussed in detail in Privacy Policy (HIPAA). A copy of the Privacy Policy can be found on our website or can be mailed to you upon request. For reference, these exceptions are listed below:
   a. I have given written authorization for the release of information.
   b. In instances where the counselor believes I am at risk of harming myself or others.
   c. When there has been an indication or report of physical, emotional, or sexual abuse, exploitation, and/or neglect towards a child, disabled person, or elderly person.
   d. When clinical records are subpoenaed by a legal entity.
3. In the event counseling or support is taking place in a group setting, participants will be advised to treat what is being discussed during the group as confidential and to not share information with others outside of the group.
4. I 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.
5. I understand that grief counselors are bound by the laws, licensing, and regulations in North Carolina. As such, I agree that I will be residing in North Carolina while receiving grief counseling services and agree to contact the grief counselor if I am in another state or have a change in my address.
6. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of Transitions GriefCare and its staff, that the transmission of my information could be disrupted or distorted by technical failures or outages; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
7. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor believes I would be better served by another form of therapeutic services (e.g., face-to-face services or longer-term counseling services) I will be scheduled an appointment or referred to a professional 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. Results cannot be guaranteed or assured.

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I UNDERSTAND THAT I AM RESPONSIBLE FOR:

1. Providing the necessary telecommunication equipment/internet access.
2. The information security on my computer or device and ensuring that I am in a private location where the session cannot be overheard by others. I am required to inform my counselor if there are any others in the room who I believe may overhear the session.
3. Arranging a location with sufficient lighting and privacy that is free from intrusions.
4. Minimizing distractions and background noises by turning off TVs and music, closing the door, and arranging for dependent care.
5. Not playing games on a device, using social media, or working on other things while receiving services.
6. Maintaining a one-on-one session. I may not invite others into session time without discussing with my counselor first.
7. Securing written permission for any screenshots, photos, and recordings which are otherwise STRICTLY prohibited. Failure to comply will result in immediate termination of the session, online services, and may result in termination of services.

EMERGENCIES

My local emergency contact's name: _____; phone number: _____

I accept that Transitions GriefCare does not directly provide emergency services and that normal business hours are 8:30am–5:00pm Monday–Friday, except on holidays.

If I am experiencing a mental health emergency, I can:

1. Call 911 or proceed to the nearest psychiatric hospital or emergency room for help.
2. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)
3. Contact Mental Health First Responders in my area:
   a. Freedom House Recovery Center (Orange & Durham County): 919-967-8844
   b. Daymark Recovery Services (Granville & Franklin County) 1-866-275-9552
   c. Therapeutic Alternative Services (Wake, Harnett, Johnston & Chatham counties) 1-877-626-1772

By signing this form, I certify that:

I have read or had this form read to me, and that I understand and agree to the information provided above. I have been given ample opportunity to ask questions and my questions have been answered to my satisfaction.

_____ _____

Signature Date

_____ _____

Printed name of person completing the form, if not the client Relationship to client

If you are unable to print and sign this document, you may digitally sign it by typing your name in the Signature box above.

Transitions® GriefCare
919.719.7199
transitionslifecare.org/grief-care

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