LIVE WELL COUNSELING
Theresa Wray LCSW LCADC
Linwood Professional Plaza, 2021 New Road; Unit 10, Linwood NJ 08221

TELEHEALTH INFORMED CONSENT

Telehealth is the delivery of clinical mental health services through secure, technology-assisted communication between a therapist and client located in different physical locations.

Emergency Protocols
Your therapist must know your physical location at the start of each telehealth session in case of emergency. You will be asked to provide your current location and an emergency contact name and phone number. This contact will be used only to assist in obtaining emergency care if a life-threatening situation occurs.

Conditions and Risks
Telehealth services may only be provided when you are physically located in a state where your therapist is licensed to practice. You may withdraw consent for telehealth at any time without affecting your right to future care. Telehealth involves risks, including technology failures, service interruptions, limited ability to respond to emergencies, and possible breaches of confidentiality despite reasonable safeguards.

Telehealth sessions may not be recorded by either party. Laws protecting the confidentiality of protected health information (PHI) apply to telehealth services, except where disclosure is permitted or required by law, including mandatory reporting, danger to self or others, or a valid court order. If you experience suicidal or homicidal thoughts, active psychosis, or a mental health crisis that cannot be adequately managed via telehealth, services may be discontinued and a higher level of care may be required.

If technical difficulties occur, the session will be ended and restarted. If reconnection is not possible within ten minutes, the session may be rescheduled. Your therapist may contact your emergency contact and/or appropriate authorities in the event of an emergency.

You are encouraged to verify telehealth coverage with your insurance provider. You remain responsible for all fees related to therapy services, including those denied or not covered by insurance. No additional fees are charged solely for the use of telehealth.

Agreement

By signing below, you acknowledge that this information has been provided and explained in a manner you understand, that your questions have been answered, and that you consent to receive mental health services via telehealth.

_____ _____
Client Name Date of Birth

_____ _____
Signature of Client Date