Distance Counseling Client Agreement

Sarah Looney is a Telemental Health Provider. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am requesting that Sarah Looney provide distance counseling (which may include phone, email, or online platforms) on an as-needed basis. Please initial all of the following.

\_\_\_\_\_ Unlike face to face counseling, I understand that when using distance counseling communication methods, privacy cannot be guaranteed. I understaff that while my counselor will maintain the privacy of written notes and the information contained therein to the fullest extent of the law, it is not possible to know whether part or all of the distance communications may be intercepted by a third party.

\_\_\_\_\_ I understand that many methods of distance counseling (including Skype, and some email platforms) are not HIPAA compliant. I agree to release my counselor from any liability that may result from the misuse of my personal information by an unknown third party who may gain access to the information via the distance counseling platform.

\_\_\_\_\_ in the event that my counselor is concerned about my personal safety or that another person with whom I am involved, I give permission to my counselor to call any or all of the phone numbers that I have provided below.

 Local Police Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Fire Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Closest Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Primary Care Physician or Psychiatrist (Name, phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family or close friend: (Name, Phone, Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ I understand that distance counseling is not always as effective as face-to-face counseling for some clients. At any time, either my counselor or I may determine that distance counseling is not appropriate for my situation. If that is the case, I will take responsibility for seeking a counselor closer to my home with whom I can develop a face-to-face relationship. Further, I release my therapist from any liability that may occur if distance counseling is not effective for me.

\_\_\_\_\_ If my counselor provides me with the names and phone numbers of counselors who are in closer proximity to my residence, I understand that providing this list does not mean that my counselor endorses any of the professionals, but rather the list is merely a starting point for developing a new counseling relationship. I am not limited to this list and understand that I am responsible evaluation counselors to determine most appropriate fit.

\_\_\_\_\_ I agree that if issues should arrive between my therapist and me, I will forgo any legal complaints in my current state of residence, and agree to defer to, and abide be all laws pertaining to Licensed Professional Counselors in the state of Texas.

**I have carefully read and agree to all of the above statements:**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_