New Perspectives Counseling, LLC.
INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES (SOUTH CAROLINA)

I hereby consent to engage in distance counseling with Cindy Priest Entrekin, MA, LPC for psychotherapy. I understand that distance counseling includes the practice of mental health care delivery, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. The interactive system used by Cindy is HIPPA compliant and I understand that I am responsible for confidentiality when using the interactive system from my point of origin, i.e. no other people in the room, private location, etc.

What You Can Expect from Online Treatment:
The duration of treatment is different for each person and can be difficult to estimate. I am happy to address any concerns that you have about this. If you are not satisfied with your treatment for any reason, please discuss this directly with me so we can work to uncover what may be preventing your progress, modify goals if appropriate, or make a referral for another profession if you so request. Sometimes people find they have a temporary increase in their level of stress in the beginning stages of psychotherapy because the process of working on personal issues can be difficult.

You, as the client understand that telemental health sessions have limitations (as well as benefits) compared to in-person sessions, among those being the lack of “personal” face-to-face interactions and the fact most insurance companies will not cover this type of therapy. You understand that telemental health is not a substitution for medication under the care of a psychiatrist or doctor. You understand that online therapy is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. If a life-threatening crisis should occur, you agree to go to the nearest emergency room or call 911 for assistance.

As a client, you understand that online therapy is technical in nature and that there are times there could be problems with Internet connectivity, which is the fault of neither the online counselor or yourself. For best results, using internet services with the fastest transmission will be most effective. Internet availability may be limited or disrupted by things such as main-made disasters (internet viruses, etc). These types of problems are beyond the control of the counselor and client. If something like this were to occur, any scheduled appointments would be re-scheduled.
You understand that you must be at least 18 years of age to consent to online counseling. You also understand that I may be required to violate confidentiality to make appropriate legal notifications if I reasonably suspect you are involved in child or elder abuse or neglect, or if you intend to harm yourself or someone else.

Payment for Services:
Payment for sessions will be made through Stripe with doxy.me or Square services. You will be charged a session fee of $120 for a 50-minute session. Please recognize that during the process of online counseling psychotherapy (as in person-to-person psychotherapy), discomfort may arise as difficult issues are addressed and worked through. This is a necessary part of online therapy, even though it does not guarantee resolution of any kind or assure success for online counseling, either explicit or implied. This means there is no guarantee as to the outcome from the services of telemental health services. This includes limitation or restriction, of any guarantee, for information, online counseling, uninterrupted access, and other services provided. In addition, as a client you can end services at any time, for any reason, without prior notification or explanation. Although, a note explaining any decision to stop services would be greatly appreciated.

Telephone and Emergency Procedures:
If you need to speak to me between sessions, please call 201-407-7355 (I am usually in the office between 9am-5pm EST T-F). Your call will be returned as soon as possible. Message are checked daily during business hours (M-F). If an emergency situation arises that requires immediate attention, you should dial 911 or go to the nearest emergency room.

Cancellation policy:
You will be billed at half my hourly rate if you miss an appointment without providing at least 24-hours notice.

Confidentiality:
I will make every effort to keep all information confidential. Likewise, if we are working online together, it is your responsibility to determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. You are encouraged to only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, email to schedule a new session time.

I have taken all the steps to ensure the confidentiality of online communication between us by using a HIPPA compliant platform but cannot guarantee the security of Internet transmissions. You permanently agree to release and indemnify Cindy Entrekin from all suits,
claims, and other actions originating from the use of telemental health services provided.

**Emergency Contact:**
In order to ensure that you are safe, please provide me with an emergency contact. This person would be contact in the event that I feel you are a serious risk to hurting yourself or others. If you are currently under the care of a physician who is treating you for mental health concerns, please provide me with his/her details and a release of information so collaboration for continuity of care can be established.

Emergency Contact Name: ________________________________
Your Relationship To the Person: ________________________________
Emergency Contact Phone Number: ________________________________
Emergency Contact Address: ________________________________
Physician Name: ________________________________
Physician Address: ________________________________
Physician Phone Number: ________________________________
Last appointment: ________________________________

I acknowledge that I have received, read and understand Cindy Entrekin of New Perspectives Counseling, Inc. Professional Disclosure Statement for Telemental Health Services, HIPPA Client’s Rights and Consent for Treatment. I further acknowledge that I seek and consent to treatment with Cindy Entrekin, MA, LPC. My signature confirms that I understand and accept all of the information contained in the Professional Disclosure Statement for Telemental Health Services, Client’s Rights and Consent for Treatment.

_____________________________________________________ ___________________________
Client Signature         Date

(Please sign, date, and return via email: cindy@newperspectivescounselingllc.com.)