RECOVERY & WELLNESS
MENTAL HEALTH COUNSELING SERVICES, PLLC

Johanna Korby, LMHC, CASAC, NCC, MAC, SAP

11 Marshall Road, Suite 2L
Wappingers Falls, NY 12590

963 US Route 6
Mahopac, NY 10541

896 N Federal Hwy 427
Lantana, FL 33462

Tel: 845 321-5644
Email: jkorby@live.com

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with Johanna Korby, LMHC, SAP, as part of my evaluation and/or counseling services. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

☐ 1) I understand that I have the right to withdraw consent at any time.

☐ 2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

☐ 3) I understand that during a telemental health session, if technological issues cause a premature end to the session, we will attempt to re-engage via video or phone call. If we are unable to reconnect within ten minutes, please call me at 845 321.5644 to continue the session via telephone or to discuss re-scheduling.

☐ 4) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

☐ 5) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; mental/emotional health become an issue in a legal proceeding).

☐ 6) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, you will be urged to call 911 or a mental health hotline, and or go to your nearest emergency room. It may be determined that telemental health services are not adequate and a higher level of care may be advisable.

☐ 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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EMERGENCY PROTOCOLS

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to assist in determining/going to your location, calling for crisis intervention, and/or taking you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____

_____

_____

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction. I have either requested or I am aware that I have access to a formal Confidentiality Notice to Patients (available on Recovery & Wellness website). I have access to and/or have reviewed my Client Rights statement (also available on Recovery & Wellness website).

_____ _____
Signature or verbal consent of client/parent/legal guardian Date

_____ _____
Signature of therapist or verbal discussion/agreement with client Date

Please fill out and email to: jkorby@live.com