



Telehealth Counseling Informed Consent

Client Name: Date of Birth:

I, the undersigned, consent to participate in telehealth counseling services with New Source Counseling Centers. Telehealth may include mental health assessment, treatment planning, and counseling provided through secure video, telephone, or other approved communication methods, governed by the same professional and ethical standards as in-person care.

I understand and agree to the following:

1. **Existing Consents Apply.** New Source Counseling Centers' Notice of Privacy Practices, Client Information forms, and general Informed Consent forms apply fully to telehealth services.
2. **Secure Platform.** Sessions are conducted through a HIPAA-compliant, encrypted platform. Despite these protections, no electronic transmission is entirely risk-free. Risks include potential data interception, unauthorized access, third-party platform vulnerabilities, and limitations in visual or verbal cues inherent to remote communication.
3. **Clinical Appropriateness.** Telehealth is appropriate for many but not all clinical presentations. My counselor retains clinical discretion to recommend in-person services, crisis services, referral, or a higher level of care if telehealth is not clinically appropriate for my needs.
4. **Licensure & Location.** Services are provided under Ohio licensure. I must be physically located in a state where my counselor is licensed to practice at the time of each session. I will notify my counselor in advance if I will be in a different state during a scheduled session.
5. **Session Environment.** I will conduct sessions from a private, safe location where I cannot be overheard or observed, and where I can give my full attention to the session. I will ensure no one can see my screen, avoid using public or unsecured Wi-Fi, and will not participate in telehealth while driving, operating machinery, or engaged in any activity that could compromise safety, privacy, or full participation.
6. **Physical Location & Emergency Procedures.** I agree to provide my current physical address at the start of each session and will update my counselor if my location changes during the session. I agree to provide an emergency contact. In the event of a clinical emergency or safety concern, my counselor may contact emergency services, crisis services, or my emergency contact as permitted or required by law and professional ethics.
7. **Technology Failures.** If the connection is lost during a session, my counselor will attempt to reconnect via the platform. If reconnection is unsuccessful, my counselor will contact me by phone to continue or reschedule the session. If contact cannot be reestablished and a safety concern exists, my counselor may initiate emergency procedures.
8. **No Recording.** Telehealth sessions may not be recorded by either party unless prior written consent has been obtained from all required parties. Unauthorized recording may have legal consequences and will be grounds for termination of the therapeutic relationship.
9. **Billing & Insurance.** Telehealth billing and insurance coverage may differ from in-person services. I am responsible for understanding my insurance benefits, coverage limits, copays, deductibles, and any non-covered services related to telehealth.
10. **Client Equipment Responsibility.** I am responsible for providing the necessary equipment (computer, tablet, or phone) and a reliable internet connection sufficient for telehealth sessions.

11. **Minor Clients.** If the client is a minor, a parent or legal guardian must sign this form. The parent/guardian and counselor will discuss privacy, supervision, emergency procedures, and any applicable limits to confidentiality as they apply to telehealth services.
12. **Right to Withdraw Consent.** I may withdraw consent for telehealth services at any time. Withdrawal may require transitioning to in-person services, referral, or another appropriate treatment option, and will be handled collaboratively with my counselor.
13. **Receipt of This Form.** I acknowledge that I have received a copy of this signed consent form and have had the opportunity to ask questions about telehealth counseling services.

I have read, understand, and agree to the information above regarding telehealth counseling services.

Client Name:

Client Signature:

Date:

Parent/Guardian Name (if applicable):

Parent/Guardian Signature:

Date:

Counselor Signature:

Date: