Limits of Confidentiality/Inform Consent

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide, steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

Animal Abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: Complying with required laws to protect vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Minors/Guardianship: Parents or legal guardians have the right to access a minor client's health information. The age of an adult for psychotherapy is 18 in the state of Nevada.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above---stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above--stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information, I understand that I will be provided a Release of Information form.

Telehealth

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Care2Counsel mental health professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical data.

Rights and Responsibilities: I understand that I have these rights and responsibilities with respect to telehealth:

I understand that the laws that protect the confidentiality of my personal information also apply to telehealth and that the information disclosed by me during the course of my sessions is generally confidential. However, I am aware that contact via email may pose an opportunity for security risk. I will do my best to protect my password and access to my data to reduce security breaches. I understand that confidentiality limits may not apply when there is suspected child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. However, I understand that if I discontinue use of telehealth and do not live locally, and thus terminate treatment, I am responsible for seeking alternate mental health services if needed. I understand that there are risks and consequences when using telehealth, including, but not limited to, the possibility that the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Care2Counsel utilizes secure services to provide telehealth. I understand that if there are people or organizations in my life that I don't want accessing communications with my therapist, it is my responsibility to take measures to keep my communications safe and confidential. I understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio /video-/computer-based psychotherapy services.

If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand that different states have different regulations for the use of telehealth. I understand that my counselor, under Nevada State Law, will not provide telehealth services to me if I am not physically in a location in which they are licensed and/or registered to practice. I understand that telehealth communications will occur on a scheduled basis and will not be provided to me spontaneously. I understand that by phone, my therapist will only discuss treatment coordination or scheduling, and by text and email, my counselor will only discuss scheduling. I understand that should I wish to have a conversation at greater length with my therapist, I can contact my counselor by one of these methods to schedule a session. I understand that in order to participate in telehealth services, it is my responsibility to provide my own device, hardware, and internet and to secure a location conducive to participating in telehealth and protect my privacy. I also understand that technological difficulties sometimes arise, and may interrupt services, and that I am still responsible for any payment obligations.

Payment for Telehealth Services: I understand that I am responsible for any payment obligations similar to in-person services. I have read and understand the information provided above regarding telehealth and agree to receive Telehealth services on either an on-going basis or as an adjunct / substitute for face to face services as determined between me and my therapist. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Signature: _____Date:_____