

We are committed to protecting the well-being of our clients. Many people are concerned about the spread

of COVID-19. We are especially motivated to protect those clients who are over the age of 60 and those who

have underlying health conditions that place them at greater risk if they contract the virus.

In an effort to protect and continue to provide mental health services, we are offering the option of

*telemental* health sessions. We urge you to utilize this service, for a time limited period, which will not exceed the

disaster emergency.

By signing this form, you agree to begin utilizing telemental health services.

Please read thoroughly, initial each line and then sign below:

\_\_\_\_\_\_\_\_\_\_\_\_ I understand that telemental health is a new delivery method for professional services, in an

area not yet fully validated by research, and may have potential risks, possibly including some that are not yet

recognized.

\_\_\_\_\_\_\_\_\_\_\_\_ I will meet with my therapist in a private location with minimal distractions to ensure my confidentiality and discretion. If this is not possible, I will discuss options with my therapist to plan for a phone session or discuss meeting in-person. Your therapist is ethically responsible for meeting all HIPAA guidelines and confidentiality protocols (no different than if you are meeting for an in-person session).

If the client is a child, I will ensure that my child/adolescent has a private area to meet for every session.

\_\_\_\_\_\_\_\_\_\_\_\_ Among the risks that are presently recognized is the possibility that the technology will fail

before or during the session, that the transmitted information in any form will be unclear or inadequate for

proper use in the session and that the information could be intercepted by an unauthorized person or persons.

\_\_\_\_\_\_\_\_\_\_\_\_ In rare instances, security protocols could fail, causing a breach of privacy of personal health

information.

Client Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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