Quest Counseling LLC

Charlayne Wall, MS, LCPC, CS
101 11th Ave South Nampa ID 83651
(208)615-3956

TELEHEALTH INFORMED CONSENT

I, _____ agree to participate in telephonic or videoconference consultation with Charlayne Wall, MS, LCPC, CS ("provider"). This means I authorize information related to my medical and mental health and health care to be electronically transmitted in the form of images and data through a telephone or interactive video connection to and from the above-named provider, other persons involved in my health care, and the staff operating the consultation equipment, if applicable.

I understand I will be informed of the identities of all parties if any others are present during the consultation and of their purpose for attending the consultation.

My provider has explained how the telehealth consultation is performed and how it will be used for my treatment. My health care provider has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

In brief, I understand my provider will not be physically in my presence. Instead, we will see and / or hear each other electronically. Some information my provider would ordinarily get in face-to-face consultation may not be available in teleconsultation. I understand such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to touch me or to render any emergency assistance.

I understand telehealth consultation(s) are a new form of treatment, in an area not yet fully validated by research, and they have potential risks, possibly including some not yet recognized. Among the risks that are presently recognized are the possibility the technology will fail before or during the consultation, the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and the information may be intercepted by an unauthorized person or persons.

I authorize the release of information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, and clinical or medical record information.

I understand at any time, the consultation(s) can be discontinued by me. I further understand I do not have to answer any question I feel is inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate in the consultation(s) will not affect my continued treatment, and that no action will be taken against me. I acknowledge, however,

that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger myself or others.

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of going without treatment. I understand that I can pursue in-person consultations. I understand that the telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the consultation's effectiveness.

I understand my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. I understand consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand I am ordinarily guaranteed access to my medical records and copies of records of consultation(s) are available to me on my written request. I also understand, however, if my provider, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, they may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and I may have to pay a fee to get a copy.

I have received a copy of my provider's contact information, including name, telephone number, voice mail number, business address, mailing address, and e-mail address. I am aware my provider may contact the proper authorities in case of an emergency. During our first session, we will discuss an emergency response plan. I acknowledge, however, if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telehealth consultation. Instead, I will seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

I unconditionally release and discharge Charlayne Wall from any liability in connection with my participation in the remote consultation(s).

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I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telehealth telephonic and/or videoconference consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Client Printed Name: _____Date: _____

Client Signature:_____Date:_____

Counselor Signature: _____Date:_____