Family Therapy Center of Northern Virginia, llc

Tele-Mental Health Services Informed Consent/Agreement

_____ I am requesting tele-mental health services with _____.
I understand that risks may occur when participating in long distance therapy. I agree to secure my environment to insure that our sessions are private. This may include but is not limited to wearing headphones and being alone in the room with a closed door.

_____ I agree that video based sessions are the safest way for my therapist to assess my mental and physical well being long distance. I agree to participate in video based versus audio alone based sessions whenever possible.

_____ I understand that every state and country has different protocols for responding to mental health emergencies. In the state or county that I will reside during tele-mental health sessions, the following is the protocol for mental health safety: I do/will reside in _____ (state/county). The entity that responds to mental health emergencies for my area is: _____. This entity's phone number is _____.

_____ My physical address for emergency services during our tele-mental health sessions is or will be:
_____.

_____ I understand that video services may become unintentionally interrupted during my tele-session. In the case of session interruption, my therapist can reach me at the following number: _____. This is a _____ landline OR ____ mobile or _____ (other).

_____ In the rare event that the therapist is feeling the need to contact my emergency contact person, the following person is within proximity of me when I am receiving tele-mental health services: Name: _____ Relationship: _____ Phone # _____.

_____ In the rare event that the therapist is feeling the need to contact my emergency contact person, the following person can be contacted. This person may or may not be within proximity of me when I am receiving tele-mental health services.
Name: _____ Relationship:
_____ Phone # _____.

_____ I have filled out and signed a general Informed Consent for Therapy form in addition to this Tele-Mental Health Services Informed Consent/ Agreement.

Client Name: _____ Date: _____

Signature: _____