THE NEUROPSYCHOLOGY CONSULTANTS, P.A.

Neuropsychological Evaluation, Rehabilitation Neuropsychology,
Neurobehavioral Management, Clinical Psychology
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CONSENT FORM FOR TELEMENTAL HEALTH SERVICES THAT IS INCLUDED WITH OTHER INTAKE PAPERWWORK REQUIRED BY THE THE NEUROPSYCHOLOGY CONSULTANTS, PA

Client Name:

I,_____, agree to participate in teletherapy with a mental health provider at The Neuropsychology Consultants, PA.

This means that:

- **I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between this therapist and noted patient .**
- **I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.**
- **My therapist has explained how the teletherapy system works and how it will be used for my treatment.**
- **My therapist has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.**
- **I understand that my therapist will not be physically present during my teletherapy session. Instead, we will see each other electronically.**
- **I understand that teletherapy is an evolving modality for therapy.**

As such, there may be potential risks that may not yet be recognized.

- Potential risks include: a) at times the video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I authorize the release of information pertaining to me determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.
- I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My therapist will refer me to a local mental health provider who can provide face-to-face services or will assume face to face services as needed.
- I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.
- My therapist has explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in person.
- I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.
- I understand that as part of receiving teletherapy, some information will be used for billing purposes. No identifying information will be revealed to anyone other than those involved in my treatment at THE NEUROPSYCHOLOGY CONSULTANTS, PA.

The contact information for my therapist or Psychologist is:

- Name:_____
- Email:_____@mindspring.com
- Phone: 919-785-9944

These are the names and phone numbers of my local emergency contacts:

- Therapist:_____
- Psychiatrist:_____
- Primary care physician:_____
- Local hospital emergency room:_____

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Name	Date
Witness	Date
Parent or Legal Guardian	Date

PLEASE MAIL THIS DOCUMENT TO:

THE NEUROPSYCHOLOGY CONSULTANTS, PA
3509 HAWORTH DRIVE, SUITE 404
RALEIGH, NC 27609