Marisa Campanella-Harris, LPC LLC

NJ License: 37PC00620300

CONSENT FOR TELEHEALTH SESSIONS

Name of patient: _____

Date of Birth: _____/_____/_____

Name of parent/guardian if patient is a minor child: _____

Introduction: Telehealth involves the use of telecommunications technology to provide real time health care to clients at a distance. This tool can be used to provide psychotherapy services, mental health evaluations, to consult with other providers, provide professional consultation, supervision, etc. Telehealth will be delivered using video-conferencing by mobile phones, tablets, and desktop computers. It can be provided to a patient/client at home, work, clinic, hospital or any other places with access through mobile devices.

Confidentiality: To protect your confidentiality the telehealth service is provided through TheraNest, a secured, encrypted, HIPAA compliant tool.

Online therapy is not appropriate for those with emergent psychiatric illnesses. **It is not appropriate for** those in severe distress, including individuals experiencing suicidal ideation, homicidal ideation, violent thoughts, self harming behaviors, dissociation, psychosis, among other disorders or situations. **Clients in severe distress must contact the National Suicide Hotline at 1-800-273-8255, visit their closest emergency room or crisis center IMMEDIATELY** to be screened to determine the appropriate level of care for you.

Payment for Services: Some health insurances pay for this service. If the service is not covered by your insurance, the regular psychotherapy fee will apply. **Payments for services (co-pays, deductible, co-insurance, and self paid rate) must be made at the time of each session.**

Cancellation policy: You will be billed at your full fee rate if you miss an appointment without providing at least 24 hours notice. You will be sent a reminder text or email the day before our scheduled session.

Marisa Campanella-Harris, LPC is committed to safeguarding and protecting your personal information (health information, etc.). By signing this form, I understand and acknowledge the following:

Please Initial

_____I am 18 years of age or older to consent for this service for myself or for

_____ (Parent or legal guardian).

_____Although Marisa Campanella-Harris, LPC has taken the necessary measures to ensure the confidentiality and privacy of online communication(s) between you and her, these actions, in whole or in part, cannot guarantee the security of internet transmissions. I, permanently agree to release and indemnify Marisa Campanella-Harris, LPC from all suits, claims, and other actions originating from psychotherapy provided through Telehealth.

_____Online therapy is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. If a life-threatening crisis should occur, I agree to contact the National Suicide Hotline at 1-800-273-8255, call 911, or go to a hospital emergency room.

_____ Marisa Campanella-Harris, LPC will break confidentiality if she believes that the person served is presenting with suicidal and/or homicidal ideation.

_____I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth, and that no information obtained in the use of telemedicine which identifies me will be disclosed to others without my consent.

_____Telehealth is technical in nature and there may be problems with internet connectivity. Internet availability may be limited or disrupted. These types of problems are beyond the control of Marisa Campanella-Harris, LPC. If something like this were to occur during a psychotherapy session, please contact Marisa 201-897-2221.

_____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.

_____ Marisa Campanella-Harris, LPC will follow the laws and professional regulations of the State of New Jersey. I agree that I reside in New Jersey.

_____I consent to treatment via Telehealth (Telebehavioral Health Services /online therapy). A copy of this release shall have the same force and effect as the original.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Provider Signature: _____ Date: _____