Drew Prochniak, MA, LPC, LMHC
2119 NE Halsey St
Portland, OR 97232

P: 503.308.9408
F: 888.972.9148
www.dprochniak.com

REMOTE COUNSELING INFORMED CONSENT

I understand and agree to receive telementalhealth services from my counselor, Drew Prochniak, LPC, LMHC. This means that my counselor and I will, through a live interactive video and/or telephone connection, meet for scheduled counseling sessions under the conditions outlined in this document and the Informed Consent / Professional Disclosure Statement form.

I understand the potential risks of telementalhealth, which may include the following:

1. the video connection may not work, or it may stop working during a session;
2. the video or audio transmission may not be clear; and
3. I may be asked to go to my therapist's office in person if it is determined that telementalhealth is not an appropriate method of treatment for me.

Initial _____

I recognize the benefits of telementalhealth, which may include the following:

1. time commitment for treatment due to the elimination of travel;
2. ability to receive services in a location other than Drew Prochniak, LPC, LMHC.

Initial _____

I give my consent to engage in counseling via videoconferencing and/or telephone conferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality and privacy. Furthermore, I understand that recording my sessions is prohibited.

Initial _____

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location.

Initial _____

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety. As such, I commit to being clear, understanding and cooperative regarding sharing my present location at the time of any and all telementalhealth services.

Initial _____

I understand that telementalhealth services can only be provided if I am physically located in the State of Oregon or Washington. I will be asked to confirm my location at the onset of our our session.

Your signature indicates you have read, agree to and understand the above information.

_____ _____
Client Date