~Counseling, Coaching, Consulting, & Clinical Assessments~

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Telehealth and Coaching Sponsored by Blink Session

I understand that the service provided through Tempo of Tampa Bay, Inc. is not intended for crisis situations and urgent needs. In a crisis situation, I agree to call 911 or local emergency services, or visit the nearest emergency room. Information shared with my counselor is confidential except in the following circumstances: If I present as a danger to myself or others, mandated reporting of abuse of children or elders, or if I sign a release of information.

Informed Consent

Informed Consent for Psychotherapy, Coaching, Music Therapy

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy\coaching. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and possible repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

If a client threatens grave bodily harm or death to another person.

If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

Suspected neglect of the parties named in items #3 and # 4.

If a court of law issues a legitimate subpoena for information stated on the subpoena.

If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy/coaching space.

Consent for Telehealth Services

CONSENT FOR TELEHEALTH SESSION

I understand that I will be provided absolute confidentiality and privacy from my therapist/coach within the session location. I will agree to have no visitors or onlookers in the session unless specially requested by myself to the provider.

My provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Availability

I understand my counselor/coach may not be available to me 24 hours a day and I am willing to

utilize appropriate time frames for return messages. I understand the most effective use of my time with my provider will be through video or live chat.

STATEMENT OF UNDERSTANDING:

I have read and understand this document of Informed Consent for Telehealth, and have had the opportunity to ask questions regarding its contents.

Client_____Date_____

Parent or Guardian, if minor_____Date_____

Provider_____Date_____