Counseling Services
C2101, General Studies Building
Blountville, TN 37617
423.323.0211 counseling@northeaststate.edu

INFORMED CONSENT FOR COUNSELING SERVICES

Introduction: Welcome to Northeast State Counseling Services. This informed consent document is a legal document; please read it carefully before signing. Please speak with your counselor if you have any questions before signing this document. You may request a copy of it for your own records.

Provision of Services: Counseling Services are provided by a Licensed Professional Counselor/Mental Health Service Provider License #3832 and interns completing their master's degree in Counseling or Social Work. Counseling sessions with interns may be audiotaped in order to help them be more effective in their work with you. Client confidentiality will be maintained if sessions are audiotaped. Interns receive both on-campus and off-campus supervision. In addition, when necessary effective counseling sometimes requires counselors to receive consultation from off and/or on campus professionals, however, student confidentiality is always maintained.

The focus of counseling at Northeast State is to help enrolled students succeed at the college. Counseling Services offers:

- Short term counseling
- Crisis intervention
- Referral

Students who are diagnosed with long-term psychiatric conditions, require ongoing therapy, or have issues outside of the scope of practice or expertise of the counselors will be provided with a list of community mental health agencies. Therefore, during the initial assessment and throughout the counseling relationship, you and your counselor will work to determine how best to serve your needs. If it is determined that you would be better served by another community resource, you will be given referral information for community mental health providers.

Confidentiality: Counseling Services counselors (both professional and student) adhere to ethical and legal requirements concerning confidentially in the counseling relationship. Communication between the client and therapist is kept strictly confidential (outside of supervision and/or consultation), unless the client gives written permission for the information to be revealed to a third party, or if disclosure is required and permissible by law. Clery Act offenses will be disclosed without using personal identifiable information.

Please note that the following exceptions apply to the confidentiality of client information:

- When the counselor believes the client may cause serious and foreseeable harm to another person or harm to self
- When there are clear suspicions of child abuse, abuse of people with disabilities, or elder abuse
- When records are mandated by a court

My signature indicates that I have read the above information and agree to abide by its terms.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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Informed Consent Addendum - Telemental Health

Telemental Health is available and an option when the college is closed to students or students are unable to attend in person due to health concerns or transportation issues.

I, _____, hereby consent to participate in telemental health

with, Denise Walker, License #3832, as part of my psychotherapy.

I understand telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1)I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to discuss since we may reconnect within ten minutes, please call me at 423.323.0211.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case there is concern I am in a mental health emergency.

Emergency Protocols
I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. Or you understand the police could be called if my emergency contact is not available.

In case of an emergency, my location is: _____ and my emergency contact is
Person's name _____
Address _____
Cell/Best phone contact _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____
Signature of client Date

_____
Signature of therapist Date