CARMICHAEL COUNSELING

Kirk Carmichael, LIMHP, LADC
www.carmichaelcounseling.org

110 N 37th Street, Ste 301 Norfolk, NE, 68701
Phone: (402) 750-1222

TELEHEALTH AND TELETHERAPY PATIENT CONSENT FORM

I, _____ agree to receive mental health and substance abuse counseling, as a Telehealth service. I understand that the provider, Kirk Carmichael, LIMHP, LADC, is providing services from Carmichael Counseling located at 110 North 37th Street, Suite 301, Norfolk, Nebraska.

Telehealth services allow me to receive treatment from a practitioner at a distance using an encrypted web-based platform. Telehealth services may complete my treatment or be my primary method of participation.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a behavioral health practitioner in-person if I decline the Telehealth service.
- If I decline the Telehealth service, I will be informed of the other options/alternatives available for me, including in-person services, are as follows: see alternative providers in your community.
- I understand that my provider may request that I participate in occasional in-person session or consult with a local health care provider in my community as part of my treatment.
- I understand that Telehealth servies become unsuitable for any reason, I may be referred to another service provider or service.
- The same confiditiality protections that apply to my other behavioral health services aso apply to the Telehealth service. I understand that I am responsible for ensuring my own privacy in the location from which I choose to participate in Telehealth services.
- I will have access to all information resulting from the Telehealth service as provided by law.
- I will be informed of all people who will be present at all sites during my Telehealth service. I may request that students or other observers be excluded from my Telehealth session.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- If an urgent need arises during a Telehalth session, I understand that my practitioner my refer me to an appropriate emergency service or request an emergency response, to my location, on my behalf.
- I understand that I must physically be in the state of Nebraska during my telehealth session as my therapist is licenced to provide services in Nebraska.

By signing below, I certify that I have read and understand the above mentioned and am the client, client's guardian, power of attorney, parent, or am duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ Date Signed: _____
Client Signature

_____ _____
Parent, Guardian, Authorized Representative Signature Witness Signature

_____ _____
Relationship to Client Kirk Carmichael, LIMHP, LADC

Revised 2/2022