Telecommunications Consent Form

As a client receiving psychological services that may involve non-secure communication methods (i.e. email, phone calls, text messages, voicemail) I understand:

1. Using these non-secure technologies allows for greater convenience in service delivery. There are risks in transmitting information over these methods that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption in service due to technical difficulties. My therapist and I will regularly assess the appropriateness of continuing to use these non-secure methods of communication in the context of our treatment.

2. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

   In emergency situations: In the event of a psychiatric emergency, I will not rely on email, texting, or voicemail options to communicate with my therapist. Instead, I will dial 911 or proceed to my nearest emergency room for evaluation. After doing so, I will call (330) 722-4166 to get in contact with my therapist.

   Should service be disrupted (e.g. email questions not responded to, text not responded to, etc.): During normal business hours, I will call (330) 722-4166 and leave a voicemail message or ask the support staff member to give a message to my therapist. I may typically expect a returned call within 24 hours.

   For other communication: I can call (330) 722-4166 at any time. During business hours, I can leave a message with support staff or may leave a voicemail message for my therapist. After business hours I may leave a message with our answering service. I may typically expect a returned call within 24 hours.

3. It is my responsibility to maintain confidentiality on the client end of the communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communication.

4. I will take the following precautions to ensure my communications are directed only to my therapist or other individuals involved in my treatment at Cornerstone Psychological and Counseling Services, LLC.:

5. My communications with my psychologist will be stored in the following manner:

6. When using non-secure communication forms, I will use as little personally-identifying information as possible and will not use these methods to disclose clinical information. For example, I will use email to confirm appointments or inquire about the status of an evaluation but will not discuss personal, clinical information until my next scheduled session.

My preferred phone number is _____
My preferred email address is_____
I will accept text messages from my therapist, if my therapist desires Yes No
I will accept emails from my therapist, if my therapist desires Yes No
It is OK to leave a voicemail message on my preferred phone Yes No

_____
Client Printed Name

_____
Signature of Client or Legal Guardian/Date

_____
Printed Name of Therapist

_____
Signature of Therapist/Date