G. Reid Doster, DMin., LPC-S, LMFT
Video Counseling Informed Consent

Client's Name: ______________________________

Date of Birth: ______________________________

By signing this form, I understand there are always potential risks associated with the use of live video counseling, although these risks are minimal:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the counselor;
- Delays in evaluation and treatment could occur due to equipment failure;
- In very rare instances, security protocols could fail, causing a possible breach of privacy, although every effort is made to eliminate this risk;
- Laws protecting privacy and confidentiality apply and no personal identifying information will be disclosed to anyone without my consent;
- I have the right to withhold or withdraw my consent to the use of video counseling in the course of my care at any time, without giving up my right to future care or treatment;
- I understand there is no stored data and no recordings from live, interactive encounters by means of TeleMental.net;
- A variety of alternative methods of Behavioral Health care may be available to me, and I may choose one or more of these at any time;
- I understand no results can be guaranteed or assured.

Patient Consent
Having read and understood the information provided above, have discussed it with my counselor, and received satisfactory answers to my questions, I consent to the use of live video counseling in my treatment.

Signature of Client, Parent or Guardian: ______________________________

If authorized signer, your relationship to patient: ________________________

Date: _____________