Serenity Counseling LCSW PLLC
20 Medford Avenue Suite 109
Patchogue, New York 11772
Phone 704-458-3025
fpredarrow1@gmail.com

---

1. I , ____ [print name], am receiving counseling services at Serenity Counseling LCSW PLLC __________ (initial).

2. Frances Red Arrow, LCSW, is my Counselor. __________ (initial).

3. I understand that I am receiving telemental health counseling services through the electronic communication of Doxy.Me __________ (initial).

4. I understand that these methods of electronic communication are not necessarily secure and are potentially subject to being viewed by other persons. __________ (initial).

5. I expressly agree and consent to receive counseling services by means of electronic communication as noted above. __________ (initial).

6. I expressly agree that should my counselor Frances Red Arrow, LCSW and I experience technical failure before or during our telemental health session we will utilize telephone communication instead. __________(initial).

7. I understand and expreslly agree that should my counselor Frances Red Arrow, LCSW and I need to utilize telephone communication due to telemental health technical failure we will not be able to visually see each other. ___________(initial).

8. I expressly agree that should my counselor Frances Red Arrow, LCSW and I experience telemental health and telephone technical failure our session will be terminated and rescheduled for a later date. ___________(initial).

9. I understand that my counselor, Frances Red Arrow, LCSW may not be available between sessions. __________ (initial).

10. I expressly agree that should my counselor, Frances Red Arrow, LCSW not be available between sessions I am to seek other medical assistance, such as but not limited, to my Primary Care Physician, Psychiatrist, Psychologist. _________(initial).

11. I expressly agree and understand that my counselor, Frances Red Arrow, LCSW is not available for emergency services and should an emergency arise I am to call 911 and/or head immediately to my nearest emergency room. __________(initial).

12. I expressly agree that should my counselor Frances Red Arrow, LCSW determine that telemental health services are no longer appropriate due to but not limited to the following reasons, safety,

efficacy of patient's support system, current medical status, competence around technology of videoconferencing during any time of treatment, this service will be terminated and I will be referred for alternate services. __________(initial).

13. I further expressly agree that should I not be in agreement with treatment referrals made by my counselor, Frances Red Arrow, LCSW it will be my full responsibility to seek out alternative services on my own. __________(initial).

14. I understand that my patient information will be stored in a locked file cabinet located at 20 Medford Avenue, Suite 109 Patchogue, NY 11772 __________(initial).

15. I further expressly agree that I, for myself, my heirs, executors and administrators, indemnify, hold harmless, waive, release and forever discharge Serenity Counseling LCSW PLLC, the individual Counselor named above, their agents, employees, officers and staff from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or relating to any loss, injury or property damage that may occur, result or be sustained during or arising out of participation in such counseling services and specifically such counseling services which occur through *via* or associated through electronic communication, whether or not such damages, injuries or losses are due to, are caused by or result from negligence.

16. I have signed this document, freely, knowingly, understandingly and voluntarily without any coercion, promise of reward or threat whatsoever. __________ (initial).

____

Patient/Client Print Name Date

____

Patient/Client Signature Date

____

Parent/Guardian Print Name Date

____

Parent/Guardian Signature Date