

Dr. Cheryl Outen, LPC
Telemental Health Crisis Protocol
In Virginia Only

Name:			
DOB:			
Last 4 of SSN:			
Phone Number:		Pass Word: <small>(For security measures)</small>	
Email:			

All locations in which you will/could use for your telemental health session:	
<u>Location description:</u> Home/work/school/etc.	<u>Location address:</u>

Emergency Plan

Dr. Cheryl Outen, LPC will see you in the event of a crisis. If I am unavailable I will provide the contact information of a colleague. If my colleague or I are unavailable in the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in Telemental health services.

<u>Emergency Contact</u>	
<u>Emergency Contact Name</u>	<u>Emergency Contact Telephone Number</u>

<u>Hospital Location</u>	
<u>Hospital Name</u>	<u>Location/Phone Number</u>

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You may alternatively follow this plan:

1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911.
3. Go to the emergency room of your choice.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a **secure and private location so that others cannot hear my conversation**. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Patient/Client Signature

Parent, Guardian or Legal Representative Signature (if minor or needed otherwise)

Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Dr. Cheryl Outen, LPC