

Gregory S. Rusk, LISW, DCSW  
1117 Fehl Lane  
Cincinnati, OH 45230  
800.730.8921

---

## TELEBEHAVIORAL HEALTH COUNSELING CONSENT

I, ( \_\_\_\_\_ ) agree to receive Telebehavioral Health Counseling, also called Internet Counseling, for the issues and symptoms I have presented to Gregory S. Rusk, LISW via the Internet. In signing this form I will present myself via the Internet in a truthful representation as to the person I am with the issues and symptoms I am experiencing. I consent to participate in the following Telebehavioral Health modalities as determined to be clinically appropriate by Gregory S. Rusk, LISW:

1. Individual Telebehavioral Health Counseling, including substance abuse counseling.
2. If a need for direct in-person services arises, such as a more intensive level of treatment in my community, it is my responsibility to contact practitioners in my area such as \_\_\_\_\_ or \_\_\_\_\_ or \_\_\_\_\_ to contact my primary care physician if do not have a local clinician or if my behavioral practitioner is unavailable.
3. If a need for medication evaluation/management in my community arises it is my responsibility to contact \_\_\_\_\_ or \_\_\_\_\_ or \_\_\_\_\_ to contact my primary care physician if do not have a physician that can prescribe medication for me.
4. If the need arises I will seek a referral to community support/self-help groups in my area.
5. The following are names and telephone numbers of my local emergency contacts, including local physician, crisis hotline, trusted family or friend(s):  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

6. If I think I may be facing a crisis situation that could result in harm to me or another person I will not seek a Telebehavioral Health consultation and will call my local emergency services at 911 or go to the nearest hospital emergency department.
7. If Telebehavioral Health services should be interrupted for a technical reason then I can be contacted at the following phone # \_\_\_\_\_ or by TEXT messaging that number. Another way to reach me is \_\_\_\_\_
8. I also understand that it is my responsibility to insure the privacy on my end of communications with Gregory S. Rusk, LISW. This means insuring privacy during our telecommunications and any records that I keep. I will be utilizing my own private computer/tablet or smart phone that is secure and protected by whatever means I feel is necessary.

I will be fully informed of recommendations and realize that following them is my own choice. I further agree to fully participate in a mutually agreed upon counseling plan that is designed to improve the issue(s) and/or symptom(s) for which I am seeking counseling. I accept the responsibility to negotiate a counseling plan to the best of my ability. I also understand that I, or Gregory S. Rusk, LISW, can terminate this agreement for Telebehavioral Health Counseling at any time without jeopardizing my access to future care or services.

I further agree to fully pay all fees for Telebehavioral Health Counseling services. Gregory S. Rusk, LISW will comply with the State of Ohio's standards of Social Work practice and professional conduct, including those for electronic service delivery. I understand that no video or audio recordings of my session will be made without my written consent. I further understand that notes of each session will be made in a chart that will be maintained in a confidential manner by Gregory S. Rusk, LISW and will not be kept in an electronic format.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Please sign, witness and date, then return by mail to the above address,**

**Or email to [gusrusk@gmail.com](mailto:gusrusk@gmail.com)**

**Or fax to (513) 832-2993**