



ABIDE

INTEGRATIVE COUNSELING
SERVICES, LLC

"Renewing Hope, Inspiring Growth, Rebuilding Lives"

Emergency Contact Information

I require an Emergency Contact Person(s) (ECP) who I may contact on your behalf in case you have a crisis or an life-threatening emergency that I cannot address while providing teletherapy services or if I assess that you need immediate care, I would like your permission to contact your emergency contact person(s). Please share the name(s) of the person(s) you wish to list as your emergency contact. This information will only be used for that purpose only.

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.

Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above.

* **Primary Emergency Contact Name** _____

Relationship: _____

Phone Number: _____

Email (optional): _____

* **Second Emergency Contact Name** _____

Relationship: _____

Phone Number: _____

Email (optional): _____

By signing this form you agree that Abide Integrative Counseling Services, LLC has your permission to call/text/ email your emergency contact(s) during a crisis or an emergency.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT

Client Name (Please Print)

Date

Client Signature

Date

(If Applicable:)

Parent's or Legal Guardian's Name (Please Print)

Date

Parent's or Legal Guardian's Signature

Date

The signature of the Therapist below indicates that they have discussed this form with you and has answered any questions you have regarding this information.

Therapist's Signature

Date