Test 7, Test:

Adult and Child Counseling · Private - Cash Pay

Report Information

Report Type: Consent for Telehealth
Status: Draft
Report Date: 12/17/2021
Performed By: Dalcour, Jennie

Christian Family Care - Consent for Telehealth Services

(Each adult client must sign their own consent form)

2346 North Central Avenue, Phoenix, AZ 85004, 602.234.1935, Fax: 602.234.0022
3275 W. Ina Road. Suite 155, Tucson, AZ 85741, 570.296.8255
3611 Crossings Drive, Suite A, Prescott, AZ 86305, 928.443.1150

Name of adult or child to receive counseling or coaching services:

Test Test 7

Consent for Telehealth Therapy

1. I understand I am beginning telehealth counseling services.
2. My counselor explained to me how the video conferencing technology that will be used to affect such a therapy session will not be the same as a direct client/counseling visit due to the fact that I will not be in the same room as my counselor. There will be no Christian Family Care staff members at my location. The counseling provider will be physically located in the Christian Family Care office or another private, confidential location.
3. I understand that I must be physically present in the state of Arizona for each counseling session. My provider will verify my location at each session, and I will need to provide my current address if not located at home.
4. I understand that a telehealth therapy session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including possible interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. If telehealth services are deemed not appropriate due to access to technology, access to a confidential environment, developmental inappropriateness, or other reasons a referral can be made for in-person services.
6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
7. I understand that my provider will email me a link to the HIPAA-compliant telehealth video conferencing platform before the session. If any technical issues arise, I can contact the provider via email or phone, or I can call the main office at (602) 234-1935. My provider and I will choose to use a different HIPAA-compliant telehealth platform or complete the session via phone.
8. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of telehealth counseling services.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Name of adult or parent/guardian

<*EN1>

Date of signature below

<*ED1>

Signature

Clear Signature

Single Line Text

<*EN2>

Date

<*ED2>

Signature

Clear Signature

Client Signature

Clear Signature