AUTHORIZATION FOR TREATMENT
INFORMED CONSENT & POLICIES (TELEHEALTH)

Client Name: _____
Last First Middle

Telehealth at Child Parent Counseling, LLC (C is utilized via a HIPPA compliant secure portal to connect the mental health professional and individual using interactive and audio communications. The initial intake will be completed in-person at our office however sessions thereafter may be in-person in our office or using telehealth.

I understand that I have the rights with respect to telehealth:

1. I authorize a licensed therapist (LCPC, LCSW, etc.) employed by CPC, to provide telehealth services that may include: diagnosis, treatment, treatment planning and referral.
2. I understand that no guarantee or assurance is being made as to the results that may be achieved through telehealth.
3. My co-payment or full amount, if self-pay, is due at the time of service. Payment via credit card may be accepted at the time of service. We will attempt to bill for telehealth services through your insurance provider when applicable. I authorize the release of medical information necessary to bill my insurance for telehealth therapy sessions.
4. I understand that if my mental health provider believes that I may be better served by another form of intervention, I will be referred to a mental health professional associated with this intervention.
5. I agree to participate in telehealth using video conferencing technology. I understand that at my request or the direction of my mental health provider, I may be directed to "face-to-face" psychotherapy.
6. Telehealth may include the anticipated benefit of improving access to care and having more efficient evaluation and management. I understand that no results can be guaranteed or assured. All appointments will be scheduled between the provider and patient.
7. I agree to keep confidentiality of other parties in the same telehealth session who may be utilizing the secure portal for group or family sessions. I agree to access telehealth in a private and confidential setting.
8. I understand that in certain situations such as emergencies or crisis, telehealth services may be inappropriate. I agree to disclose my location to my provider during a telehealth session. If I am in emergency or crisis, I should immediately call 9-1-1 or seek immediate help from a crisis-oriented health care facility or emergency room at the nearest hospital.
9. I understand that CPC will keep all my personal information confidential, except for the following special situations as required by law or quality assurance:
10. I agree that in order for CPC to best serve clients, I accept the following policy: appointments may be cancelled if CPC is notified at least one business day before the scheduled session. A $40 no-show fee for appointments cancelled less than 24 hours will be charged payable prior to the next appointment. Repeated no-show appointments and cancellations may be a reason for termination and referral to other services. CPC may need to cancel appointments from time to time due to unforeseen circumstances. CPC will attempt to give as much notice as possible.
11. I understand that I am protected through a grievance procedure, which is free from coercion, discrimination, and reprisal and that I have the right to file a grievance if it becomes necessary. I will first discuss my concern with my therapist and if still unsatisfied, I will submit a written document to outline my concern to CPC. I understand that if I feel my therapist/CPC is committing an ethical violation, I can contact the Board of Professional Counselors and Therapists, which regulates all licensed and certified counselors and therapists:

    4201 Patterson Avenue Baltimore, MD 21215-2299 Phone: 410-764-4732 Fax: (410) 358-1610

12. I understand that CPC receives, originates, maintains, discloses, & uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. This information may be used to perform the following tasks: diagnose my medical/psychiatric/psychological condition, plan my treatment, communicate with other health professionals concerning my care, and document services for payment/reimbursement, and conduct routine health care operations, such as quality assurance audits. Electronic health records are used to secure your information. Any paper records are kept under lock and key.
13. I have the right to refuse telehealth treatment. The potential consequences of refusing treatment will be reviewed. My ability to access telehealth services in the future will not be jeopardized.

Child Parent COUNSELING, LLC

Client Name: _____
Last First

14. I have the right to review my records, unless prohibited by law, or deemed harmful to the person.
15. I understand there are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. I understand the possibility that, despite reasonable efforts on the part of my provider, transmission or storage of my personal information could be interrupted by unauthorized persons. CPC uses secure encrypted audio/video transmission software to deliver telehealth. My provider and I will regularly reassess the appropriateness of continuing telehealth services as we have agreed upon today and modify our plan as needed.

I have read and understand the information provided above regarding telehealth, have discussed it with my provider and all of my questions have been answered to my satisfaction. I understand the potential risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my consent to participate in the use of telehealth services for treatment under the terms described herein.

_____	_____	_____
Client (print name)	Client signature	Date
_____	_____	_____
Parent/guardian (print name)	Parent/guardian signature	Date
_____	_____	_____
Therapist	Therapist signature	Date

224 Mayo Road, Suite E Edgewater, MD 21037
Phone: (410) 798-8028 Fax: (410) 649-5256
www.childparentcounseling.com