Family Health Care

ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Date: _____

Patient Name: _____

DOB: _____

INFORMED CONSENT TO TREATMENT — ADULT

I acknowledge that I have received, have read (or have had read to me), and understand the "Family Health Care Behavioral Health Program Orientation" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in outpatient counseling at the Family Health Care program. I understand that participating in an initial evaluation, developing a treatment plan, and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my assigned therapist/program. I am aware that I may stop my treatment with my assigned therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I may be discharged from treatment due to non-participation.

I understand that Federal laws and regulations protect my health information to that extent afforded by the laws (See 42 U/S.S. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR (SUD) part 2 for Federal regulations). Exceptions to this law or instances when your information may be released include:

- Written Consent by the client
- Internal Communications within the agency, as necessary
- Medical Emergencies
- Court Order
- Crime at Program/against program personnel
- Research with no client-identifying information
- Audit and Evaluation by external agency/entity as required for licensure/accreditation
- Suspicion of Abuse and/or Neglect against a Child or vulnerable Adult
- A Qualified Service Organization/Business Associate Agreement
- Insurance Company or third party payer for billing purposes

Telehealth Treatment — check here if you are willing to engage in Telehealth counseling as an option ☐

I consent to engaging in telehealth services with Family Health Care to participate in a telemedicine service using Videoconferencing. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/The Patient will not be in the same room as the healthcare provider performing the service.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic.

3. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either the healthcare provider or I can discontinue the telemedicine service if we believe that the videoconferencing connections are not adequate for the situation.
4. I understand that the telemedicine session will not be audio or video recorded at any time.
5. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I understand that I will be informed of any other users in the room during my visit (technical support).
6. I/the patient understand that my/the patient's insurance will be billed for telemedicine services. I/the patient understand that if my insurance does not cover telemedicine services I/the patient will be billed directly for the provision of telemedicine services.
7. I agree that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I acknowledge I have been told that if I feel I am suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
8. I have read this document, understand the risk and benefits of the telemedicine services and have had my questions regarding the services explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.
9. I am voluntarily providing my e-mail address to receive links for Telehealth appointments and giving my consent to have links e-mailed to me for those appointments.

In- Person Treatment ☐ Telehealth Treatment ☐ E-Mail Address:_____

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed Name Relationship (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent.

_____ _____
Signature of Therapist Date

☐ Copy accepted by Client ☐ Copy Declined by Client ☐ Copy Kept by Therapist