DOB: ___ / ___ / ___
MRN: _____

Informed Consent for Treatment Services

Appointments

Your appointment time is reserved for you. It is your responsibility to notify Hurtt Family Health Clinic (HFHC) at (714) 247-0300 in advance if you are unable to make your appointment. HFHC will then notify you therapist, and set up another appointment. In the event of a no show, other treatment options will be explored and mental health services within the clinic may be limited to same-day appointments only.

Confidentiality

HFHC is an integrative health care clinic. The information you discuss with your therapist is confidential and cannot be released without your consent. Your therapist may talk with you about what will be shared with medical providers and psychiatry in order to ensure teamwork, patient-care, and effectively meet your needs. There are certain circumstances however, under which your therapist is legally required to disclose personal information shared in a session.

These include:

1. If there is a reasonable belief or suspicion that child abuse has occurred.
2. If there is a reasonable belief or suspicion that elder or dependent adult abuse has occur.
3. If you make a threat to harm another person.
4. If you pose a risk to yourself or other.

Minor Confidentiality: A 12-year old minor may consent for therapy without parent's approval. The 12-year old minor is responsible for the payment. The information discussed by the minor is confidential and will not be released without the minors consent. If the minor agrees to the release of information to the parent, it is the therapist's decision whether the information is released to parents. The therapist may choose to provide a summary of treatment rather than confidential notes to protect the patient and maintain relationship with the patient.

Parents' Initials: _____

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Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Hurtt Family Health Clinic's mental health professionals to connect with individuals using interactive video and audio communication such as, computers, mobile devices to access mental health care services remotely.

Telehealth Consent

Telehealth access will be determine by mental health therapist to identify suitability, capacity for electronics and risk level. There are certain limitations and risks associated with technology:

1. Breach of Privacy and Security during live video conference between patient and provider.
2. Privacy and security of documentation and information.
3. Equipment software connectivity.
4. Establishing the provider-patient relationship with the use of telehealth technologies.

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

1. The laws that protect the confidentiality of my personal information also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. HFHC utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

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6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
11. I understand that different states have different regulations for the use of telehealth. In California, Telehealth may only be conducted with patients that are permanent residents in the state of California. I understand that, in California, I am not able to connect form a different state for the provision of audio-/video-/ computer based psychotherapy services.

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my initials below, I hereby state that I have read, understood, and agree to the terms of this document.

I consent to the allow clinic to audio/video record (telehealth) the therapy session.

Initials: _____

I consent and understand limitations and risks associated with technology.

Initials: _____

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Record Keeping:

Your therapist will keep notes of his/her impression of your work in counseling. These details will be limited, but enough for your therapist to review your progress and keep track of developments in your work together. These records will be kept in a documented chart, which will be locked in the office building. The Mental Health therapist should provide the client with reasonable access to records concerning themselves. However, if therapist is concerned that the clients' access to records could cause serious misunderstanding or harm to the client then, the the Mental Health therapist would limit client's access to records, or portion of the records.

Your signature on this form shows that you understand the above facts. It also allows your therapist to treat your minor child (if relevant). Please feel free to discuss any concerns you may have with your therapist as they arise.

Client Signature: _____ Date: _____

Print Name: _____

Clients' Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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