Caring Community Counseling
A Healing Center
Caring for our community one person at a time

PATIENT REGISTRATION

Pinellas: 3840 5TH Ave N Saint Pete FL 33713 **Phone:** 727-367-2273 **Fax:** 727-800-6929 **Pasco:** 7340 Little Rd New Port Richie FL 34654

TELE-HEALTH CONSENT FORM

I (name) _____ agree to receive telehealth mental health services at Caring Community Counseling (CCC).

I understand that Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. This consent is valid for six months for follow-up Telehealth services with the CCC provider.

I also understand that:

- I can decline Telehealth services at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a mental health practitioner if I decline telehealth services.
- If I decline the Telehealth services, the other options/alternatives available for me, including in-person services.
- I understand that Telehealth treatment is different from in-person treatment and that if my therapist believes I am better served by in person treatment, I will be referred to a therapist in my geographic area that can provide such services.
- I have the right to the same confidentiality with Telehealth under the same laws that protect the confidentiality of in-person sessions. Any information disclosed by me during the course of my therapy, therefore is generally confidential.
- There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats I may make towards a reasonably identifiable person. I also understand that if I am in such a mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I further understand that there are risks unique and specific to Telehealth, including by not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months and will be renewed after: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian or Legal Representative Date

REFUSAL of TELEHEALTH SERVICES

By signing below, I _____ declare my intention to **refuse** Telehealth services. I understand that this means I may be put on a waiting list until an in-person counselor becomes available.