CW Counseling and Consulting, LLC

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMENTAL HEALTH THERAPY/ CONSULTATION

The purpose of this form is to obtain your consent to participate in **Telemental Health or Video Conferencing** with the following therapist :_____ at CW Counseling and Consulting, LLC.

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1) **Purpose and Benefits.** The purpose of this authorization is to use **Telemental Health or Video Conferencing** to enable patients to get therapy by the therapist without the inconvenience and expense of traveling.

2) **Nature of Telemental Health or Video Conferencing**: During the **Telemental Health or Video Conferencing**:
   a) CW Counseling therapists through the use of interactive video, audio and telecommunications technology will provide therapy to you, your child and family.
   b) An assessment of you, your child or family may take place.
   c) Nonmedical technical personnel may be present in the **Telemental Health or Video Conferencing** to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the **Telemental Health or Video Conferencing** visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this **Telemental Health or Video Conferencing**. Additionally, dissemination of any patient-identifiable images or information from this **Telemental Health or Video Conferencing** interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the **Telemental Health or Video Conferencing**. All existing confidentiality protections under federal and South Carolina State law apply to information disclosed during this **Telemental Health or Video Conferencing**.

5) **Risks and Consequences.** The **Telemental Health or Video Conferencing** will be similar to a routine therapy office visit, except interactive video technology will allow you, your child or family to communicate with the therapist at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver therapy, healthcare and educational services is a new technology and may not be equivalent to direct patient to therapist contact. Following the **Telemental Health or Video Conferencing**, your therapist may recommend a visit to the office for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the **Telemental Health or Video Conferencing** at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the therapist in person if you travel to his or her location.

7) **Financial Agreement.** This **Telemental Health or Video Conferencing** will be paid for by your insurance or any other way you have paid for treatment. You and/or your insurance company, EAP or Medicaid will be billed for services rendered.

I have been advised of all the potential risks, consequences and benefits of **Telemental Health or Video Conferencing.** My therapist or designee from CW Counseling and Consulting, LLC has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:_____ **Date**:_____
Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient:_____

Witness:_____ **Date**:_____