F.A.I.R. COUNSELING

I _____ *(Name of Patient)* hereby consent to engaging in telehealth at Families and Adolescents in Recovery, Inc as part of my treatment. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information both orally and visually, to other practitioners, and for scheduling and billing purposes at Families and Adolescents in Recovery. Due to recent advances in technology, the field of telehealth has continued to evolve. This allows individuals to have access to mental health professionals by removing barriers such as travel, illness, etc. However, the research has not caught up with the advancement and therefore the efficacy of treatment may not be equivalent to that of in-person therapy. Therefore, we must be vigilant of your progress and evaluate the effectiveness of this form of therapy.

For initial sessions with new patients, I may request that you be interviewed in-person by a professional and allow me to talk to that individual before proceeding with treatment.

Confidentiality still applies for telehealth services, and nobody will record the session without the permission from other person(s). However, exceptions to maintaining confidentiality include reporting child, elder, and dependent adult abuse; harm to self or others; or threats of violence towards an identified person based on Duty To Warn.

A. I agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.

B. I understand that I need to use a webcam or smartphone during the session.

C. I understand that it is required to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

D. I understand that it is important to use a secure internet connection rather than public/free Wi-Fi.

E. I understand that it is important to be on time. If you need to cancel or change your tele-appointment, you must notify you provider in advance by phone or email.

F. I agree to provide a back-up plan (e.g. phone number) where I can be reached to restart the session or to reschedule it, in the event of technical problems.

G. I will identify the closest Emergency Room to your location, in the event of a crisis situation.

H. I understand that I have the right to withhold or withdraw my consent for telehealth at any time without it affecting future treatment.

I. I understand that I should confirm with your insurance company that the telehealth sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

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J. I agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.

K. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.

L. As your provider, we may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Patient's Name _____ Patient's Signature _____

Patient's Email _____ Patient's Phone # _____

Parent/Guardian's Info required for Patients younger than 18.

Parent/Guardian's Name _____ Parent/Guardian's Signature _____

Parent/Guardian's Email _____ Parent/Guardian's Phone # _____

Date _____