# Child Focus, Inc. Consent for Telehealth

Client Name: _____ Date of Birth: _____

I give consent for the above named client to receive **Telehealth** services at Child Focus, Inc. Telehealth service is provided real-time through audio and video telecommunication technology in which the client and treating service provider are at different locations. I understand that telehealth secure videoconferencing may be used intermittently when I am unable to get to the appointment or at regularly scheduled intervals.

I understand I have the right to be informed of the risks and benefits of the proposed service, of alternative treatments, and of no treatment.

- *Benefits* of Telehealth may include: Increased access to mental health services, less wait time and distance travel required for appointments, improved care coordination with mental health providers, access to expertise from a distant specialist. There are no *Benefits* associated with refusal of Telehealth service.

- *Risks* associated with Telehealth may include: There is a small risk that equipment failure may result in broken communication with the service provider or the experience of poor video or audio quality. There is a slight risk that a delay in evaluation or treatment could result from a deficiency or equipment failure. There is a minuscule risk that security protocols could fail, causing a breach of privacy of personal health information. *Alternative Treatment*: Includes face-to-face therapy service. The *Risk* associated with refusing Telehealth service may include worsening of mental health symptoms and functioning.

I understand I have the right to be oriented to telecommunication secure video software.

I understand that federal and state laws which protect privacy and confidentiality of my medical information also apply to Telehealth. As such, I understand I will be required to verify and authenticate my child's and my own identity during sessions.

I understand that I have the right to consent to, or refuse, or withdraw my consent for Telehealth at any time upon full explanation of the expected consequences of such consent, refusal or withdraw.

I understand that I have the right to be informed (in advance) of the reason(s) for discontinuance of service provision, and to be involved in planning for the discontinuance of service provision whenever possible.

Only those persons with *legal custody* may provide consent for treatment.

(I have ☐ sole custody or I have ☐ shared custody of the above named child).

1. Legal guardians who are not the client's biological parent must provide proof of custody.
2. Biological parents who are not married to each other must provide court documentation of child custody agreements.
3. If you are the biological parent but do not have proof of custody, please discuss this with the registration specialist.

I give consent for the above named client to receive services from Child Focus, Inc.

| _____ | _____ | _____ |
|---|---|---|
| Parent or Guardian Signature | Relationship | Date |

I refuse to give my consent for the above named client to receive services from Child Focus, Inc. I understand the risks associated with this refusal.

| _____ | _____ | _____ |
|---|---|---|
| Parent or Guardian Signature | Relationship | Date |

Effective 1/2020