Child & Family Agency of Southeastern Connecticut, Inc.

CONSENT TO TELEHEALTH AND ELECTRONIC COMMUNICATION AGREEMENT

CONSENT TO TELEHEALTH

Telehealth allows Child and Family Agency of Southeastern CT, Inc. (CFA) providers to diagnose/evaluate, consult, treat, educate, and manage care using interactive audio, video or data communication. I hereby consent to participating in psychotherapy, psychiatric evaluation, including medication management for psychotropic medications, and medical services via telephone or the internet (hereinafter referred to as Telehealth) with my CFA providers.

I understand I have the following rights under this agreement:

1. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person appointments. Any information disclosed by me during the course of my treatment, therefore, is confidential.
    A. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such 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.
    B. Further, I understand that sharing of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my informed consent.
    C. I agree not to record and/or distribute my telehealth therapy sessions.
2. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our telehealth appointments could be disrupted or distorted by technical failures or could be interrupted.
3. You or your CFA provider(s) may determine that a higher level of care than Telehealth is required to meet your unique treatment needs, at which time a referral will be made to the appropriate provider.
4. You are responsible for payment at the time of service, including for telehealth appointments.

I have read and understand the information provided above. I have the right to discuss any of this information with my clinician and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications at any time verbally and in writing.

Telehealth agreement acknowledgement*

I have read and acknowledge the terms shown above.

ELECTRONIC COMMUNICATION AGREEMENT

I agree to communications regarding care in the following forms (*check all that apply*)*

□ Home phone _____

□ Work phone _____

Cell phone for:

□ Person receiving services (if 12 years or older) _____

□ Parent/Legal Guardian _____

Text messages can be left for:

□ Person receiving services (if 12 years or older) _____

□ Parent/Legal Guardian _____

Voicemails can be left to:

□ Person receiving services (if 12 years or older) _____

□ Parent/Legal Guardian _____