SUPPORT UNDERSTANDING GROWTH

Foundations Counseling Center

Telehealth Informed Consent Form

I_____hereby consent to temporarily engaging in telehealth-based services with providers of Foundations Counseling Center (DBA for Jennifer C Moore, MSW, LCSW, Inc,) as part of my psychotherapy. I understand that "telehealth," in this context, includes the electronic practice of mental health care (i.e., psychotherapy), diagnosis, consultation, treatment, transfer of mental health data, and/or psycho-education using interactive audio, video, or data communications. _____

Initials

Additionally, I acknowledge that telehealth-based services are being offered in lieu of in-person face-to-face treatment (unless deemed clinically inappropriate by my provider) to maintain a responsible health radius during the 2020 COVID-19 pandemic. Such social distancing measures have been recommended by the Centers for Disease Control (CDC) and the World Health Organization (WHO) at this time. I understand that I will be asked to return to in office, face-to-face treatment when the CDC and/or the WHO deems it no longer necessary to limit social contact for purposes of health control. _____

Initials

I understand the following, with respect to telehealth-based services:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and/or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical/mental health information also apply to. As such, I understand that the information disclosed by me during the course of my therapy is largely confidential. However, there are exceptions to confidentiality, including but not limited, the clinician's obligation to report child, elder, and dependent adult abuse, as well as his/her obligation to report expressed threats of violence towards an ascertainable victim. Further, confidentiality is limited in situations in which my mental and/or emotional state is a topic in a legal proceeding and/or in circumstances in which I am considered to be a threat to myself.

(3) I also understand that the dissemination of any personally identifiable/confidential information from telehealth-based interaction shall not occur without my written consent. If my provider is an intern, I understand that my provider may communicate personally identifiable information, as well as clinical information, to his/her supervisor(s).

(4) Although the telehealth site used is HIPAA compliant, I understand that there are risks associated with this service modality. Risks include, but are not limited to, the possibility that the transmission of information could be disrupted or distorted by technical failures, the transmission of personal information could be interrupted/obtained by unauthorized persons, and/or the electronic storage of personal information could be accessed by unauthorized persons. I understand that these risks remain, despite reasonable efforts on the part of my provider and Foundations Counseling Center.

(5) In addition, I understand that telehealth-based care may not be as comprehensive as in-person face-to-face services. There are potential risks and benefits associated with any form of psychotherapy, and despite my efforts, the efforts of my provider, and the efforts of Foundations Counseling Center, my condition may not improve. I may benefit from telehealth, but results cannot be assured. I also understand that if my provider believes I would be better served by more intensive or alternative services, she/he/she and will discuss those with me.

(6) I further understand that insurance plans have informed Foundations Counseling Center that telehealth services are temporarily a covered benefit. However, benefits quoted by insurance companies are never a guarantee of the way benefits are paid. I understand that I am ultimately responsible for the payment of services regardless of insurance coverage.

(7) I understand that I have a right to access my medical information and copies of medical records in accordance with Nevada law.

(8) I understand that the consent form(s)/new patient paperwork that I completed at the initiation of therapeutic services with Foundations Counseling Center still applies, in full, for telehealth-based services. I understand that I may request a copy of the documents from the front desk at any time.

I have read and understand the information provided above. I have discussed it with my provider, and all my questions have been answered to my satisfaction.

_____ _____

Signature of patient/parent/guardian | If signed by other than patient, indicate relationship

_____ _____

Date | Signature of Clinician Date