Family Counseling Service
Client Consent to Participate in TeleTherapy (Online Services)

Name of Client:_____

1. **PURPOSE.** The purpose of this form is to obtain your consent to receive Telehealth/Telemedicine services with a FCS service provider. Telehealth/Telemedicine is the provision of healthcare remotely by means of telecommunications technology.

2. **NATURE OF TELEHEALTH/TELEMEDICINE SESSIONS.** Telehealth/Telemedicine involves the use of audio, video or other electronic communications to provide assessment, counseling or educational services to you. During your Telehealth/Telemedicine sessions, details of your personal case will be discussed, just as though you were physically present to receive services. You are responsible for ensuring that all necessary steps are taken on your end to protect your privacy. It is *imperative* that you take steps to preserve the integrity of the Telehealth/Telemedicine session. These measures may include avoiding engaging in sessions in the presence of others not involved in the session, minimizing disruptions and eliminating interruptions.

3. **EQUIPMENT**. In order to receive Telehealth/Telemedicine services, the client will be responsible for acquiring and maintaining all equipment needed to receive services on their end, including a high-speed internet connection and up-to-date software for accessing online services. The device must have a camera. This could be a desktop computer, laptop, tablet or smartphone. The internet connection must be able to support a 60 to 70-minue session without interruption.

4. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of Telehealth/Telemedicine include having access to services without having to travel to the FCS office. It is possible that because of your specific situation, a face-to-face session still may be necessary after the Telehealth/Telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to Telehealth/Telemedicine consultation is a face-to-face session. Additional risks are that the counselor is unable to assure the privacy of confidential sessions on the user end and the sessions may be interrupted due to a disrupted internet connection.

5. **COUNSELOR DISCRETION**. Your counselor reserves the option of denying Telehealth/Telemedicine services if the risks pose a threat to the integrity of service provision or if the details of your specific circumstances are not conducive to conducting a therapeutically sound session remotely.

6. **CONFIDENTIALITY.** All existing confidentiality protections under federal and Alabama State laws apply to information used or disclosed during your Telehealth/Telemedicine session.

7. **RIGHTS.** You may withhold or withdraw your consent to Telehealth/Telemedicine services at any time before and/or during a session without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

8. Location. The principle location of the client while receiving the services described above is

_ (Insert name of City or County)_____in Alabama_

I understand and acknowledge the risks, benefits and details described above and hereby give my consent to receive Telehealth/Telemedicine services from Family Counseling Service.

_____ _____
Signature of Client or Client's Legal Guardian Date

Authorization to provide services to a minor client

As the parent, legal guardian, and/or custodian of _____, (child's name) I give permission for my child to be treated by Family Counseling Service. I further acknowledge and attest that I have the legal standing and authority to provide this consent. Relationship to minor client: _____

Name of individual providing this consent: _____

Signature of legal guardian/custodial parent: _____ Date: _____