TREASURE WELLNESS COUNSELING AND TRAINING CENTER
ADMINISTRATIVE OFFICE: 2176 E. FRANKLIN ROAD, SUITE 100
MERIDIAN, IDAHO 83642
208-515-7661
WWW.TREASUREWELLNESS.COM

CONSENT FOR TELEHEALTH COUNSELING SERVICES

1. I understand that I have the right to choose to engage in telehealth counseling services.
2. My health care provider explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session if it is felt the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider to ask and have answered questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE TELEHEALTH PLATFORMS

Telehealth platforms provided at Treasure Wellness Counseling and Training Center are simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the telehealth service, the telehealth service does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth services facilitate videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information on the telehealth platform – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the telehealth platform.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Email for Telehealth link to be sent: _____

Client Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Counselor Name: _____ Signature: _____ Date: _____