CHILD AND FAMILY EMPOWERMENT SERVICES, LLC

2880 W 4700 S Suite A, Taylorsville, UT 84129
Phone (801) 972-2711
Fax (801) 972-2709

"Where empowerment leads to healthy prevention"

Consent for Treatment (Minor)

I, _____ give consent for _____
Parent/Guardian Client Name

to start receiving services at Child and Family Empowerment Services as of _____
Date

For Telehealth Sessions:

1) WHAT TELEHEALTH IS: THE USE OF INTERACTIVE REAL-TIME (SYNCHRONOUS) TECHNOLOGIES SUCH AS VIDEO CONFERENCING TO DELIVER MENTAL HEALTH CARE TO PATIENTS (Centers for Medicare & Medicaid Services, 2019)

2) IDENTIFY LIMITS TO CONFIDENTIALITY (PATIENT TO SEE THE CFES DESCRIPTION OF SERVICES) AND THAT THE LAWS OF CONFIDENTIALITY APPLY TO TELEHEALTH SERVICES

3) IDENTIFY THE POTENTIAL RISKS OF CONDUCTING SERVICES VIA TELEHEALTH SUCH AS:
-LOSS OF VIDEO CONNECTION
-UNCLEAR SOUND OR VIDEO FEED
-THE NEED FOR ANOTHER STAFF TO ASSIST WITH TECHNOLOGY TROUBLESHOOTING

_____ _____
Guardian Signature Date