CENTER FOR
INTEGRATIVE PSYCHOTHERAPY

CONSENT TO TREATMENT

I, _____ , give my consent to Center for Integrative Psychotherapy to provide the following services □ to myself □ to my child _____ (check all the options that apply):
Child's Name

___ Individual Psychotherapy _____ Family Therapy _____ Couples Therapy
___ Psychological Testing _____ Biofeedback ____ Telemedicine Services

CONSENT TO TREATMENT THROUGH TELEMEDICINE SERVICES GUIDELINES

1. I understand that Center for Integrative Psychotherapy and my assigned therapist wishes me to engage in telemedicine psychotherapy.
2. I understand video conferencing technology will be used to affect psychotherapy and will not be the same as face to face patient/therapist visit due to the fact that I will not be in the same room as my therapist.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my session information will be shared with other individuals for scheduling and billing purposes. My meeting time and date will be shared with Zoom App, in order to generate meeting.
5. In an emergent consultation, I understand that the responsibility of the telemedicine Consulting therapist is to advise my assigned therapist, and that the covering therapist's responsibility will conclude upon the termination of the video conference connection.
6. I understand that billing will occur from the telemedicine encounter, and that my responsibility will be determined by my insurance coverage status, insurance plan and insurance cost share assignment.
7. I understand that I will have the opportunity to ask questions in regards to this type of therapy. My questions will be addressed and the risks, benefits and any practical alternatives will be discussed with me in a language in which I understand.

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 telemedicine service.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I understand that this consent form may be revoked by me at any time by stating my requests in writing to my rendering therapist.

I understand that the record of my treatment is confidential and my written consent must be obtained in order to release any information concerning my treatment, except as mandated by law (such as child abuse) or to prevent a clear and present danger to myself and/or another.

I understand that once my child becomes the age for consent, he/she will be eligible to self determine services, will obtain ownership of own records, and my child will have to consent in order for me or others to access those records.

My/ My Child's assigned rendering therapist(s) is/are:
(Multiple therapists assigned when family and individual therapy provided)

□ Jesus A. Salas, Psy.D. ABPP ACT
□ Melanie Bass, Ph.D.
□ Andrea Krutsick, M.Ed., LPC
□ Robin Carosella, Psy.D.
□ Cheryl Hilbert-Gonzalez, M.A., LPC, CBIS

CONSENT TO ALLOW USE OF DE-IDENTIFIED DATA FOR RESEARCH PURPOSES

I consent the use of the clinical data from my test results to be used for research purposes after the data set is stripped from identifiers, and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

I Consent ☐ **I Decline to Consent** ☐

CONSENT TO RELEASE OR OBTAIN CONFIDENTAL INFORMATION FROM PRIMARY CARE PROVIDER/PSYCHIATRIST

I authorize Center for Integrative Psychotherapy, to Disclose/Receive (circle one) information contained in my record/ my child's record (circle one) to/from:

My primary care provider: Name:_____ Phone Number: _____

My Psychiatrist: Name: _____ Phone Number: _____

For the purpose of coordination and continuity of care, the information released is confined to the following:

□ Medical History
□ Therapy notes
□ Court testimony
□Psychological Evaluations
□Treatment summary
□Dates of service
□Test scores and profiles
□Back ground information
□Other __ _____

Specific information to be disclosed: 0 copies 0 verbal consultation.

- **I understand this release will automatically expire on** _____.I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to Center for Integrative Psychotherapy. Center for Integrative Psychotherapy and its staff cannot be held legally liable for the interpretation or use by person/persons to whom they are released.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES

If you have a mental health emergency, please do not wait for communication back from me, but do one or more of the following:

- Go to the closest emergency room
- Call 911
- Call Lehigh County Crisis 610-282-3127
- Call Northampton County Crisis 610-252-9060
- Call Carbon County Crisis (800) 338-6467
- Call National Suicide Prevention lifeline at (800) 273-8255

There are additional procedures that need to be in place specific to telehealth services. These procedures are for your safety in case of an emergency and are as follows:
If you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, telehealth services are not appropriate and I may determine that you need a higher level of care. I require an Emergency Contact Person (ECP) who I may contact on your behalf if needed in a life threatening emergency. Please enter this person's name and contact information below.
In the event of an emergency, please verify that your ECP is willing and able to go to your location. Additionally, if you, your ECP, or I determine necessary, the ECP agrees take you to the hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.
Please list your ECP here:

Name:_____

Phone Number:_____

You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go in the event of a mental health emergency. Please list this hospital and contact number here:

Hospital:_____

Phone Number:_____

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.
Please list this police department and contact number below:

Police Department:_____

Phone Number:_____

My signature below indicates that I understand and agree to the contents of this form.

I have requested a copy of this form. ___ Yes ___ No

My signature below indicates that I understand and agree to the contents of this form.

I have requested a copy of this form.___ Yes ___ No

Name of Patient (Print)	Signature	Date
Name of patient (Print)	Signature	Date
Name of Guardian (if minor) (Print)	Signature	Date
Name of Clinician (Print)	Signature	Date
Jesus A. Salas, Psy. D. ABPP ACT Name of Director/Clinical Psychologist jsalas@cip-cbt.com	Jesus Salas, Psy. D. ABPP ACT Signature	Date