**CLIENT CONSENT FOR TELETHERAPY VISIT**

**3GCounseling and Assessment**

**Wanda S. Cook, M.Ed.,LPC-S**

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

**Name of Parent/Legal Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if Client is a minor): I am the legally authorized representative of the client.

**Please check if you agree:**

\_\_\_I consent to be seen by 3G Counseling and Assessment through a two-way interactive audio/video connection known as teletherapy.

\_\_\_I understand that the purpose of this teletherapy visit is specific to a behavioral health/psychiatry assessment, short-term treatment, case management and or/ consulting services and is not a substitute for medical treatment.

\_\_\_I understand that **I may request that the teletherapy visit be discontinued at any time.**

\_\_\_I authorize the release of any relevant medical information that pertains to the Client to 3G Counseling and Assessment.

\_\_\_I understand that the written record of the Client’s teletherapy visit will become part of his/her medical record and will remain strictly confidential.

\_\_\_I understand that it may be necessary for 3G Counseling and Assessment to recommend one of the following alternative settings for healthcare treatment: a. Emergency care at an emergency room b. Follow-up outpatient visit (in-person) with another specialty provider c. Admission to an in-patient hospital.

\_\_\_ I understand that there are potential problems with the use of technology for teletherapy. These may include but are not limited to the following: Interruption or disconnection to the audio/video link, an unclear picture or image, or electronic interference. If any of these problems occur, the visit might need to be discontinued.

\_\_\_I understand that 3 G Counseling and Assessment cannot guarantee the privacy or security of any teletherapy visit.

\_\_\_I understand that this teletherapy visit may not be equal to a face-to-face visit with a healthcare provider.

\_\_\_I certify that I understand the content of this form.

\_\_\_I understand that I can revoke this consent at any time by providing written notice to3G Counseling and Assessment

\_\_\_I consent to participate and receive care via teletherapy.

Signature of Client/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_

Printed Name of Client/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_