**Ebony Counseling, Consulting and Supervision**

**CONSENT FOR TELEHEALTH SERVICES AND TREATMENT**

**1.** Consent for Treatment: I consent to telehealth care performed by Ebony, McClain, Ph.D. This includes intake evaluations, assessments, therapy and other services deemed therapeutically necessary in the providers’ professional judgment. I understand that the practice of therapy is not an exact science and that diagnosis and treatment may cause emotional discomfort and/or distress at times. I also understand that I have the option to refuse the delivery of therapy services by telehealth at any time without affecting my right to future treatment.

**2.** Consent for Telehealth Services: Telehealth involves transmission of video, photographs, and/or details of my client information record (collectively, “Data”). I understand that:

* I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from my session. I will also inform my provider of anyone present in my surroundings.
* All confidentiality protections required by law or regulation will apply to my care.
* I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the time of my request.
* If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
* If an emergency occurs during a telehealth appointment when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.

**3.** Records and Release of Information: Transmitted Data may become part of my client record. Data will not be transmitted to people outside my provider except as described below, and/or if I provide additional written consent.

* I will have access to all of the information in my client record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
* Ebony McClain, Ph.D. may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations (see mandated reporter requirements in your original consent)
* All releases of information are subject to the same laws and regulations as in-person care.

I consent to telehealth services with Ebony McClain, Ph.D., LPC

Client Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent (if child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_