DISCOVERY COUNSELING & CONSULTING

Informed Consent for Outpatient Behavioral Health Treatment

Please select A and/or B and sign below

☐ A: I, the undersigned, do voluntarily consent to behavioral health assessment and treatment for myself

☐ B: I, the undersigned, am the parent/legal guardian of (child's name) _____, a minor child. I do voluntarily consent to his/her behavioral health assessment and treatment and agree to be responsible for all fees for services provided.

- I understand that behavioral health is not an exact science, and no guarantees are being made as to the results of assessment and/or treatment.
- I agree that the purpose, potential risks and benefits, and alternatives to any treatment, as well as risks of not having treatment have been explained to me, and all my questions have been answered to my satisfaction. I understand that I can decline treatment, but I consent to treatment by Discovery Counseling & Consulting (DCC) and its affiliated providers.
- I am aware that I am an active participant in my treatment and that I share the responsibility for the treatment process.
- I understand that assessment and/or treatment will be kept confidential consistent with applicable law. I have received, reviewed and I agree to the DCC Notice of Privacy Practices.
- I understand that when my clinician is unavailable, another behavioral health provider may be providing coverage. I understand that the clinician providing coverage may be given access to relevant information in order to provide the best interim care possible.
- I authorize the release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements.
- If you are a member of a Managed Care Organization a "Members Rights and Responsibilities" document may be available to you.
- You have the right to revoke this consent in writing and terminate services at any time. In that event, your clinician or other DCC staff are willing to provide information about alternative resources in the community.
- I understand that this service may be provided as a "telehealth" service through technology, potentially including video conferencing, telephone, text, and email. As such, services may not include direct face-to-face communication with my provider.
- I understand and agree that exchange of information and paperwork may be via electronic means, or via mail or fax. I understand that there are risks to electronic transmission of data, including, but not limited to, possible confidentiality breaches and theft of personal data.
- I understand that it is my responsibility to maintain privacy of information that I receive and to exercise any precautions when I am sending information to Discovery Counseling & Consulting (DCC). This includes but is not limited to: ensuring that I can hold telehealth sessions in a private space, using a secure internet connection, using security features such as password protection on devices and email accounts.
- I understand that technology is subject to periodic technical difficulties and service disruptions. I understand that DCC does not guarantee technology will be error free

or uninterrupted and any technology provided by DCC is provided as-is without warranty.

- I understand that my therapist may determine that telehealth treatment is not the appropriate method of service delivery for me, and if this happens, my therapist will discuss this decision with me, and provide me with alternate referrals and resources, as needed. I understand that it is my right to discontinue telehealth services at any time.
- I understand that I will be asked to maintain an active credit card on file for purposes of billing for telehealth sessions and I authorize DCC to charge my card for all fees and services provided.
- The laws and professional standards that apply to in-person services also apply to telehealth services. I understand that this document does not replace other agreements.

If you have any questions about this form, please discuss them with your clinician.

I have read, understand, and agree to the information on this sheet. My signature indicates my *informed consent*.

_____

Client Name

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

Relationship to Client: _____