regular business matters pertaining to our sessions. **If you elect to communicate with us via e-mail or text we will assume that you are accepting that confidentiality cannot be completely guaranteed.**

Initial:

Consenting to Treatment of Minors:
In order to ensure parents/guardians consent to and have the opportunity to participate in treatment, we must understand any custody issues. Please initial the appropriate statement:

- Both parents live together and agree to this treatment Initial:_____

- There is a formal or informal custody agreement in place, and we understand that we must provide a copy of the agreement and sign a consent for treatment in joint custody cases.

Initial:_____

- The parent/guardian signing has sole custody and will provide that paperwork.

Initial:_____

Your signature below shows that **you have received the Informed Consent for Therapy outlining the treatment policies of our practice, a notice of your HIPAA rights, and the PATIENT FINANCIAL RESPONSIBILITY STATEMENT regarding general financial policies.**

You have also had the opportunity to ask for clarification if there is anything that you do not understand. Your signature below also indicates that you personally accept financial responsibility for the services that you receive and acknowledge that no guarantees have been made to you about your treatment outcome.

My signature indicates that I have read the policies noted above that were provided to me, and that I understand and agree to all of The Center for Grief and Trauma Therapy's Policies regarding treatment, as well as policies regarding financial arrangements for any services that I receive

Client's name:_____
(Please print)

Client's signature:_____ Date:_____

Patient/Guardian Signature:_____
Date:_____

FOR TELEMEDICINE ("TELEHEALTH") CLIENTS

Your rights:

This informed consent procedure ensures that at least all of the following information is given to you or your legal representative verbally and in writing. I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of intervention (e.g. face-to-face services), I will be referred to a mental health professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth psychotherapy, but that results cannot be guaranteed or assured. I understand that there may be issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for video conferencing. I will not hold this therapist liable for any gathering or use of client information by these service providers.

(5) I understand that I have a right to access my personal information and copies of case records in accordance with Delaware or California law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. By signing this document, I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations (see or hear things others do not), if I have delusions (beliefs others may consider unrealistic), if I am in a life-threatening or emergency situation of any kind, if I am having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

The law requires that you sign a written statement prior to the delivery of health care via telemedicine, indicating that your or your legal representative understands the written information provided in 1 through 6 above and that this information has been discussed with me or his/her designee. _____(initial here)

If you have chosen the option to receive services via telemedicine (also known as "online, remote services" or "telehealth"), you should be aware of some specific requirements. First, all services are provided via Zoom and/or VSee, a HIPAA compliant live online meeting site. Should you decide to utilize this service, please note that while I ensure confidential meeting space on my end, you will need to ensure you have a space that is confidential wherever you choose to hold the session. By signing this agreement, you acknowledge that if you choose to have a session where another person(s) can hear you, then the breach of confidentiality is your choice and I am not held liable for such a breach. (initial here) _____

Additionally, you are consenting via written authority to allow contact with identified family and other treating professionals in your local area in case I need emergency backup, or in the case in which you are in need of services beyond the scope of telehealth practice (i.e., hospitalization).

By signing below, I_____(printed name) acknowledge that I have read this informed consent and have received answers to any questions to my satisfaction.

_____

Signature of Client Date:

Signature of parent (2) Date:

Signature of parent (1) Date: