

CORNERSTONE COUNSELING OF ASHLAND, LLC

Consent to Treat

Client Name _____
LAST FIRST MIDDLE

DOB _____ Date of Consent _____

Types of Service(s) to be Provided: I hereby authorize **Cornerstone Counseling of Ashland** to provide the following services to the above named client (circle the appropriate services):

Individual Counseling Group Counseling Psychological Assessment
Case Management Telebehavioral Health Other: _____

Nature of Telebehavioral Health: During the telemedicine consultation, details of your medical history, personal history, diagnoses, risk assessment, therapeutic intervention, diagnostic testing, and progress will be discussed with mental health professionals through the use of interactive video, audio, and telecommunication technology.

Benefits of Telebehavioral Health: Improved access to medical care by enabling a patient to remain in his/her home or work environment, a chance at more efficient medical evaluation and management, and the client can obtain expertise of a distant specialist.

Risks of Telebehavioral Health: There is a possibility that therapy sessions or other communication by a mental health professional could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Confidentiality: It is my understanding that such services and any information derived there from are confidential and will be treated as such by the staff of Cornerstone. Information regarding such services cannot be provided without written permission from the above named client. Exceptions to confidentiality include: Danger to self, mandatory reporting of child abuse, or others. To prevent threatened danger, therapist has the right to break confidentiality.

Consent: I voluntarily consent to the treatment described above. I am stating that there was no threat or coercive measures to induce me to sign this consent form. I hereby further release Cornerstone from all legal responsibility or liability that may arise from the act(s) that I have authorized above.

Withdrawal of Consent: I understand that I may withdraw this consent at any time except to the extent of action already taken based upon my consent. Such withdrawal must be done formally and in writing, signed and dated.

Client: _____ Date: _____

Witness: _____ Date: _____



Telebehavioral Health

We are offering Telebehavioral health services through Cornerstone Counseling of Ashland. This means secure video conference or telephone sessions with your counselor.

Secure video conference via Zoom technology:

- ★ Zoom is free to all clients. Clients do need internet access and a valid email address.
- ★ Use your smart phone, tablet or computer. (Something with video and audio capabilities).
- ★ Download the Zoom app prior to the session or you can open the private link in your browser at the time of the meeting invitation.
- ★ Prior to your session, you will receive an email from Cornerstone or your counselor inviting you to Join the Zoom meeting.
- ★ At the time of your session, click on the *join the meeting* link and open Zoom and the meeting will begin.
- ★ We can help you get started. Give it a try. It is easier than it sounds. It is a great alternative to in-person sessions.
- ★ Zoom offers secure communication through Cornerstone. We have the Zoom Health version, which is HIPAA compliant (protects your privacy) and safe to use. We strongly encourage you to protect your privacy with regard to your location during your online therapy session.
- ★ Please sign the *Telebehavioral Health Consent to Treat* form and return.