CONSENT TO TELEHEALTH REATMENT

Please read it carefully and discuss any questions you have before signing below.

Affinity clinical services provides Telehealth and face to face counseling services during this time of COVID 19. Our Telehealth services require that you participate via visual electronic Telehealth or Telephone at the time of service just as you would in person. We want to make sure that the services we provide is medically necessary and otherwise covered under your treatment agreement within our scope of license or certification.

Your Electronic or telephonic communication(s) must be documented/maintained as part of the patient's medical record. It must be sufficiently documented to the services provided.

Although we make every effort to keep your information confidential, in consistent with NCDHHS Guideline will allow non-HIPAA compliant technology such as FaceTime, zoom and Skype to be used with discretion and patient consent. We can't guarantee the confidentiality of information you shared with us during this Telehealth process.

There is a risk When using technology for communication that it may be forwarded, intercepted, circulated, stored, or even changed and the security of the devices used may be compromised. Although we make reasonable efforts to protect the privacy and security of all electronic communications with you, it is not possible to completely secure the information. If you use any other methods of electronic communication with us, other than the means recommended by us, there is a reasonable chance that a third party may be able to intercept that communication. With the use of technology, it is important to be aware that family, friends, co-workers, employers, and hackers may have access to any technology, devices, or any other device you know is safe. You are responsible for reviewing the privacy sections and agreement forms of any application and technology you use. Please contact us with any questions that you may have on privacy measures.

I have read, informed and understand The Affinity's Declaration of Telehealth Policies and Procedures and my signature below indicates my full informed consent to services provided by my counselor via telehealth treatment. I understand that my treating counselor should be and is trained accordingly as determined by his/her licensing board. If my services provider is an administrative staff or a counseling student intern in training, this form of treatment will only be used in the case of a "state of emergency." In such cases, this consent and form of treatment will end on the date the "state of emergency" is no longer in effect.

Client Signature: _____ Date:_____

Client Signature: _____ Date:_____

Clinician Signature: _____ Date:_____

Parental Authorization for Minors

I, _____, give permission for Affinity Clinical Services, PLLC
[Parent's Name]
to conduct counseling with my _____, _____.
[Name of Minor] [Type of Relationship]