Faithful Counsel
Counseling with truth in love

Telehealth Services
Ph: 219-714-7147
Fax: 219-627-1887

Parent Authorization, Agreement, and Consent for Treatment of Child

As professional counselors, our responsibility and goal is the well being of our identified clients and patients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in an agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality.

As a result, it is the policy of our practice (herein referred to as "Faithful Counsel") that all minors presented for treatment have the following authorization and consent on file.

Please check box most appropriate:

- ❑ Both Legal Parents/Guardians Consent to Treatment (Page 3)
  • Both legal parents/ guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below.
  • If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign a Consent for Mental Health Treatment Form before the child can be treated.

- ❑ Divorce, Custody or Legal Issues (Page 4)
  • There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of other parent (In this case, please provide us with a certified copy of this legal document in its entirety).

- ❑ Missing or Deceased Parent (Page 5)
  • The parent presenting the child for treatment has no access to other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bare all responsibility for such consent.

Parent(s)/Guardian(s) Initials _____ _____

Counselor's Initials_____

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The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the providers involved to create a supportive and conducive environment for treatment.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that, which will benefit your child. This means, that you each agree as a condition of us treating your child that:

• You realize limits of confidentiality. That although we maintain full confidentiality of your reports and records with our providers and office staff, we cannot enforce confidentiality among family members, parents, siblings, and / or spouses. We do, however, ask that each party respect the confidentiality of each family member.

• Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;

• You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceeding relating to the care and custody of your child;

• You understand that in the event that a provider is called into a legal or forensic relationship, or if any therapeutic material should be subpoenaed, at that point the therapeutic relationship will be considered terminated, and the provider will no longer provide counseling or related therapeutic services, but will fulfill legal obligations on a factual or forensic basis.

• If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

Parents/Guardian(s) Initials _____ _____ Counselor's Initials_____

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Parent Authorization, Agreement, and Consent for Treatment of Child

Legal Parent 1:

Both Legal Parents/Guardians Consent to Treatment

I, _____, _____ of
(*parent/legal guardian name)* *(relationship to child*)
_____, hereby authorize, with the total understanding of
(*name of child*)
the above-mentioned terms and conditions, my child(ren) to receive mental health treatment at Faithful Counsel and assume all financial responsibility for their treatment.
I affirm that I have the authority to make healthcare decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.
I understand and agree that any breach of these agreements may result in the termination of any, and all, of my (or my child(ren)'s relationship(s) with Faithful Counsel or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Printed Name of Parent: _____

Signature: _____ Date: ____/_____/____

Legal Parent 2:

I, _____, _____ of
(*parent/legal guardian name*) (*relationship to child*)
_____, hereby authorize, with the total understanding of
[name(s) of child(ren)]
the above-mentioned terms and conditions, my child(ren) to receive mental health treatment at Faithful Counsel and assume all financial responsibility for their treatment.
I affirm that I have the authority to make healthcare decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.
I understand and agree that any breach of these agreements may result in the termination of any, and all, of my (or my child(ren)'s relationship(s) with Faithful Counsel or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Printed Name of Parent: _____

Signature: _____ Date: _____

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Parent Authorization, Agreement, and Consent for Treatment of Child Divorce, Custody or Legal Issues

I, _____, _____ of
(parent/legal guardian name) *(relationship to child)*
_____, hereby acknowledge that with the total understanding
[name(s) of child(ren)]
of the above-mentioned conditions and terms of agreement I authorize my child(ren) to receive mental health treatment at Faithful Counsel and assume all financial responsibility for their treatment.
I affirm that I have the authority to make healthcare decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.
I have provided Faithful Counsel with a certified or legal copy of the divorce or custody decree that indicates that I have full authority to make any and all decisions in regards to my child's mental health treatment.
I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreements, etc. I acknowledge that Faithful Counsel is requesting any and all related documents for the benefit of my child and therefore release any liability to Faithful Counsel, any of it's providers, office staff, and/or affiliates resulting from a dispute to this authorization.
I understand and agree that any breach of these agreements may result in the termination of any, and all, of my or my child(ren)'s relationship(s) with Faithful Counsel or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Printed Name of Parent: _____

Signature: _____ Date: _____

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Parent Authorization, Agreement, and Consent for Treatment of Child--Missing or Deceased Parent

I, _____, _____ of
(parent/legal guardian name) *(relationship to child)*
_____, hereby acknowledge that with the total
[name(s) of child(ren)]
understanding of the above-mentioned conditions and terms of agreement I authorize my child(ren) to receive mental health treatment at Faithful Counsel and assume all financial responsibility for their treatment.

I affirm that I have the authority to make healthcare decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I hereby swear and affirm under any applicable perjury laws that my child(ren)'s biological/legal parent is deceased and that there is not a custody order or separation agreement that restricts or limits me from making any or all decisions in regards to my child's mental health treatment. I further acknowledge that Faithful Counsel has asked and attempted to collect any and all such documents from me.

I understand and agree that any breach of these agreements may result in the termination of any and all of my or my child(ren)'s relationship(s) with Faithful Counsel or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Printed Name of Parent: _____

Signature: _____ Date: _____

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Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications Faithful Counsel clinicians use to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:
1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. A copy of our Therapeutic Informed Consent and office policies can be provided.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

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 counselor, 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 unintentionally lost or accessed by unauthorized persons. Doxy.me utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.

4. Faithful Counsel clinicians follow the State of Indiana COMAR Regulations for tele-health: 10.32.05 as well as their respective board regulations (BOPC/ACA or BSWE/NASW) and ethics. They have also received training to provide tele-health services.

5. 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.

Payment for Telehealth Services:
Faithful Counsel will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

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Informed Consent for Telehealth Services Cont.

Patient Consent to the Use of Telehealth:
I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Name _____

Client's Signature_____Date_____