Welcome to Child and Family Guidance Center!

Our mission at Child and family Guidance Centers is to provide Quality, Accessible Mental Health Services to Help Strengthen Children, and Families, and our Community.

To achieve our mission we will work in partnership with you and ensure that you and/or your child's needs are appropriately identified and met. Our staff is dedicated to you and/or your child's recovery.

If you are a parent seeking services for your child, please complete the forms attached with the child's information. If you are here for services for yourself, please complete the forms attached. And, as always, if you have questions or need assistance, please do not hesitate to ask. We are here to help!

Today you will meet with a Therapist to determine your needs and treatment goals. This is your opportunity to discuss your concerns and develop an Individualized Recovery Plan. Once the plan has been developed, the Therapist will explain the services available that will best meet your needs.

As part of you treatment at Child and Family Guidance Center, you will be provided Parent Support and Education Groups, Adult Support Groups, and/or Peer Support Groups. Being involved in your own recovery is key to your success!

You will schedule an appointment for the Psychiatrist before leaving our office today if this has been established as a treatment goal for you and/or your child.

Thank you for choosing Child and Family Guidance Center as your place to receive supportive services and allowing us the opportunity to serve you!

Child and Family Guidance Centers
Executive Management Team

WELCOME TO CHILD AND FAMILY GUIDANCE CENTER

&

YOUR ROAD TO RECOVERY

Our mission at Child and Family Guidance Centers is to provide Quality, Accessible Mental Health Services to Help Strengthen Children, Families, and our Community.

To achieve our mission we will work in partnership with you and ensure that you and/or your child's needs are appropriately identified and met. Our staff is dedicated to you and/or your child's recovery.

To be fully involved in your and/or your child's recovery we encourage you to develop your recovery plan at this time. This plan will determine the level of assistance you need in reaching your potential, goals, and recovery. Some common beliefs we invite you to join us on are as follows;

- Recovery is the ability to manage your symptoms in a way that allows you to be active in your community, build a support network, work and/or volunteer, and be involved in activities that you enjoy.

- Recovery involves viewing your mental health as only ONE aspect of who you are. You also have assets, strengths, interest, aspirations, and the desire and ability to continue to be in control of your own life.

- Recovery is understanding that mental health is better understood-even in their most severe form-as something that co-exists with other areas of competence within your life.

- Recovery is your right as a person seeking treatment.

You and Your Recovery Team will develop a Recovery Plan. Your Recovery Team will work with you to create your plan; however the Recovery Plan is your guide for Recovery.

Attached you will find a menu of our services that are available to you and your family. Please determine what services will best meet your recovery needs and utilize them within your Recovery Plan.

Thank you for giving us the opportunity to serve you!

CLIENTS' RIGHTS

[THIS FORM IS TO BE GIVEN TO THE CLIENT TO KEEP]

Child and Family Guidance Centers acknowledges and protects the rights of its clients, which include:

- Clients have the right to impartial access to treatment, regardless of race, religion, gender, ethnicity, age, disability, or sexual orientation.

- Clients have the right to be treated in a manner that preserves and enhances their self-respect and individuality.

- Clients have the right to receive information necessary to give informed consent before the start of any procedure or treatment.

- Clients have the right to refuse treatment and to be informed of the consequences of such refusal.

- Clients have the right to actively participate in the development of an individualized treatment plan and to have the plan periodically reviewed. This includes the right to know and to meet with the professional staff members responsible for their care, to know their professional qualifications, and to know their staff positions.

- Clients have to right to obtain current information concerning their evaluation, treatment, and prognosis in understandable terms.

- Clients have the right to confidential treatment of their personal and medical records. Information from these sources will not be released without prior consent, except as required by law, or under third-party payment contracts.

- Clients have the right to voice opinions, recommendations, and grievances in relation to policies and services offered by Child and Family Guidance Centers.

- Clients have the right to refuse to participate in a research program without compromising access to services to which they are otherwise entitled.

- Clients have the right to know and participate in their discharge planning and to receive appropriate referral information prior to termination of services.

Client Rights are also available in the Texas Administrative Code, Title 25, Part 1, Ch 404, Subchapter E, RULE §404.154

MISSION

To provide quality accessible mental health services to strengthen children, families, and communities.

Child and Adolescent Recovery Services (AGES 4-17)

- **Level of Care 1**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Family Partner Supports
  - Family Case Management

- **Level of Care 2**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Counseling
  - Skills Training & Development
  - Family Partner Supports
  - Family Case Management

- **Level of Care 3**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Counseling
  - Skills Training & Development
  - Family Partner Supports

- **Level of Care: YES WAIVER**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Intensive Case Management
  - Counseling
  - Skills Training & Development
  - Family Partner Supports
  - Family Case Management
  - Parent Support Groups
  - Flexible Community and Other Supports
  - Comprehensive Services (Specialized Therapies)

Adult Recovery Services (AGES 18+)

- **Level of Care 1S**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Skills Training & Development
  - Supported Employment
  - Supported Housing

- **Level of Care 2**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Counseling
  - Skills Training & Development
  - Supported Employment
  - Supported Housing

- **Level of Care 3**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Psychosocial Rehabilitative Services
  - Supported Employment
  - Supported Housing

- **Level of Care: ACT Program**
  - Psychiatric Evaluation & Medication Management
  - Medication Training & Support
  - Routine Case Management
  - Psychosocial Rehabilitative Services
  - Counseling
  - Supported Employment

GRIEVANCE PROCEDURE
Clinical Services Department

Child and Family Guidance Centers is committed to the concerns of its clients and to receiving feedback from them. The process for a client who has a complaint or a question is to:

1. Begin by discussing the concern with your clinical provider. This will often clear up misunderstandings or simple problems.

2. If the concern is not dealt with to your satisfaction, you may speak with one of our Directors at (214) 351-3490 or Toll Free 1-866-695-3794.

3. If the concern is still not dealt with to your satisfaction, you may then put your concern in writing and mail it to the attention of:

The Executive Director
Child and Family Guidance Centers
8915 Harry Hines Blvd.
Dallas, TX 75235
Please be sure to include your phone number and mailing address.

* At any time that you feel that you have been treated unethically or your client's rights have been violated, you have the right to complain to the state board, which governs the professional discipline of the staff member, what your concern is about or contact our rights protection officer:

Texas Medical Board
333 Guadalupe
Austin, TX 78701
(512) 305-7700

Texas Board of Nursing
William P. Hobby Building
333 Guadalupe, Suite 3-460
Austin, TX 78701-3944
(512) 305-6838

Texas State Board of Examiners of Licensed Professional Counselors
100 W. 49th St.
Austin, TX 78756-3183
1-800-232-3162

Texas Board of Social Worker Examiners
1100 W. 49th St.
Austin, TX 78756-3183
1-800-232-3162

Texas Commission on Alcohol and Drug Abuse (TCADA)
9001 North I 35, Suite 105
Austin, TX 78753-5233
1-800-832-9623

U.S. Department of Disability – American's With Disability Act
950 Pennsylvania Ave, NW
Civil Rights Division
Disability Rights Section – NYA
Washington, D.C. 20530
202-307-0663

Client Rights Protection Officer / ADA Compliance Officer
Todd Wright, LPC
8915 Harry Hines Blvd
Dallas, TX 75235
214-351-3490, ext 3547

HIPAA Privacy Notice
Effective: April 14, 2003

This notice describes how your medical or health information may be used and disclosed and how you can get access to this information.
Please review it carefully.

When you receive treatment from CFGC, CFGC may get health information about you. Health information includes any information that relates to (1) your past, present, or future physical or mental health or condition (2) providing health care to you or (3) the past, present, or future payment for your health care.

This Notice tells you about your privacy rights, CFGC's duty to protect health information that identifies you, **and how CFGC may use or disclose health information that identifies you without your written permission. Please note:**

- ✧ We will not disclose information about you related to HIV/AIDS without your specific written permission, unless the law allows us to disclose the information.
- ✧ If you are also being treated for alcohol or drug abuse, federal law protects your records and regulations found in the Code of Federal Regulations at Title 42, Part 2. Violation of these laws that protect alcohol or drug abuse treatment records is a crime, and suspected violations may be reported to appropriate authorities in accordance with federal regulations.

This notice does not apply to health information that does not identify you or anyone else. Please share this Notice with everyone in your household who receives treatment from CFGC.

Your Privacy Rights

The law gives you the right to:

1. Look at or get a copy of the health information CFGC has about you, in most situations.
2. Ask CFGC to correct certain information, including certain health information, if you believe the information is wrong or incomplete.
3. Ask CFGC to limit the use or disclosure of health information about you more than the law requires.
4. Tell CFGC where and how to send messages that include health information about you, if you think sending the information to your usual address could put you in danger. You must put this request in writing, and you must be specific about where and how to contact you.
5. Request a list of disclosures of your medical record information. This list would not include disclosures prior to April 14, 2003.
6. Ask for additional copies of this Notice from CFGC.
7. Withdraw permission you have given CFGC to use or disclose health information that identifies you, unless the CFGC has already taken action based on your permission. You must withdraw your permission in writing.

CFGC's Duty to Protect Health Information

The law requires CFGC to protect the privacy of health information that identifies you. It also requires CFGC to give you this Notice of its legal duties and privacy practices. In most situations, CFGC may not use or disclose health information that identifies you without your written permission. **This Notice explains when CFGC may use or disclose health information that identifies you without your permission.**

- ✧ For all other uses and disclosures, CFGC must obtain your written permission, which you may withdraw at any time.
- ✧ If CFGC changes its privacy practices, it must notify you of the changes by mailing a new Privacy Notice to the most recent address you have given.
- ✧ CFGC employees are required to protect the privacy of health information that identifies you.

How CFGC Uses and Discloses Health Information

Payment
CFGC may use or disclose health information about you to pay or collect payment for your health care.

Health Care Operations:
We can also use your health information for health care operations such as:

- o Activities to improve health care, evaluating programs, and developing procedures;
- o Case management and care coordination.
- o Reviewing the competence, qualifications, performance of health care professionals and others.
- o Conducting training programs and resolving internal grievances.
- o Conducting accreditation, certification, licensing, or credentialing activities.
- o Providing medical review, legal services, or auditing functions.
- o Engaging in business planning and management or general administration.

Treatment:
We can use or disclose your health information to:

- o Provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider.
- o Unless you ask us not to, we may also contact you to remind you of an appointment or to offer treatment alternatives or other health-related information that may interest you.

Family member, other relative, or close personal friend
CFGC may release health information about you to a family member, other relative, or close friend when:

- You have agreed to the disclosure and the health information is related to that person's involvement with your care or payment for your care.
- You have a legally authorized representative (LAR) who is appointed by a court to represent your interests.

Government programs providing public benefits
CFGC may disclose health information about you to another government agency offering public benefits if:

- The information relates to whether you qualify for services, or receive services funded by a government assistance program and the law requires or specifically allows the disclosure or

Public health
We will disclose your health information when law or governmental regulation requires this and if directed by the public health authority.

To report suspected child abuse or neglect.
We may disclose your health information to a government authority:

- As required by law to report abuse or neglect of a child or the elderly and disabled or
- To assist in the investigation of suspected abuse and neglect.

Serious threat to health or safety
We may use or disclose your health information to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.

For judicial or administrative proceedings
CFGC may disclose health information about you in response to:

- To comply with a grand jury subpoena;
- An order from a regular or administrative court; or
- A subpoena or other discovery request by a party to a lawsuit

As required by law
CFGC must use or disclose health information about you when a law requires the use or disclosure.

Contractors
CFGC may disclose health information about you to CFGC's contractor if the contractor:

- Needs the information to perform services for the CFGC; and
- Agrees to protect the privacy of the information.

Secretary of Health and Human Services
Agencies must disclose health information about you to the Secretary of Health and Human Services when the Secretary wants it to enforce privacy protections.

Research
CFGC may use or disclose health information about you for research if information identifying you is removed from the health information.

Other uses and disclosures
CFGC may use or disclose health information about you:

- To create health information that does not identify any specific individual;
- For purposes of lawful national security activities;
- To federal officials to protect the President and others;
- To a prison or jail, if you are an inmate of that prison or jail, or to law enforcement personnel if you are in custody so that they may provide health care to you;
- To comply with workers' compensation laws or similar laws.

If you have questions about this Notice or need more information about your privacy rights, you may contact one of our Directors at the following number **214.351.3490.**

If you believe CFGC has violated your privacy rights, you may file a complaint by contacting the:

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

Texas Office of the Attorney General
By mail at P.O. Box 12548, Austin, Texas, 78711-2548,
Or by telephone at (800) 806-2092.

There will be no retaliation for filing a complaint.

child & family guidance center

Patient Information

Last Name	Suffix	First Name	Middle Name

Mailing Address	Apt/Lot	City/State	Zip Code

Phone #'s Home ( ) Work ( ) Cell ( ) Other ( )

Email Address:

Date of Birth	Gender (circle)	Social Security #
	Male Female	

Ethnicity (circle)

Hispanic/Latino
Not Hispanic/Latino
Declined

Primary Language (circle)

English, Spanish, Arabic, Cantonese, French, German, Hindi, Italian, Japanese, Korean, Mandarin, Persian, Polish, Portuguese, Romanian, Russian, Taglog, Ukranian, Urdu, Vietnamese

Race (cirlce)

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian of Other Pacific Islander
White
Other
Declined

Emergency Contact

First Name	Last Name	Home Phone Number	Cell Phone Number

Presenting Problem &Family Issues

Please make a brief statement of what has brought you and/or the client to seek services at this time:

Has the client received counseling before? (Circle) Yes No

If Yes, When/Where:

Is the client currently on medication? (Cirlce) Yes No

If Yes, Medications prescribed:

Office Use Only

Enter all patient demographic infomormation into Medisoft
Obtain copy of driver's license or indentification card
Obtain copy of front and back of insurance card
Verfiy case information setup for clinician/prescriber

General Conditions of Treatment and Financial Agreement

Client (Last name. First name, Middle initial) | Date of Birth | Social Security Number

CONSENT FOR SERVICES/GENERAL AGREEMENT

I/we hereby give my/our authorization and consent for the above-named person to receive outpatient mental health diagnostic and treatment services from the staff of Child and Family Guidance Centers. I/we understand that these services include an evaluation and assessment to help determine treatment or service needs via face to face and/or telemedicine. Should I/we receive services via telemedicine, I/we understand this will be provided through video conferencing technology, and there will be a physician extender available to me/us in the event that I/we have any questions or concerns before, during or after the session. I/we understand that it is important for me/us to provide detailed and accurate information in response to this evaluation. After the evaluation and before signing the Individualized Service Plan, I/we will receive a detailed explanation in a language or method understood by me/us of the proposed treatment program. This explanation will cover the types of services that CFGC has determined would be most beneficial. In addition, I/we will receive an explanation of alternative treatment/services to the proposed treatment program. If there are any changes to the treatment/service program, they will be explained to me/us and my/our consent for these changes will be obtained prior to the changes taking place. I/we hereby affirm that I/we have the legal authority to give this consent. I/we reserve the right to withdraw this authorization and consent by written notice at any time. I/we have had an opportunity to review this form and I/we agree with all of the provisions contained herein. I/we understand that if I/we have any reservations, I/we should not sign this form.

RELEASE OF INFORMATION

I consent and authorize Child and Family Guidance Centers to release all information contained in my financial and medical records including diagnoses and test results, to (a) my insurance company or health plan or its representatives, or its agents or independent contractors, or (b) any other person or entity that is responsible for paying or processing for payment any portion of my bill, or (c) to any person or entity affiliated with the Centers for the purposes of administration, billing, collecting and quality and risk management. This consent applies to all records created in the course of and relating to these services including those related to alcohol and/or substance abuse diagnosis or mental health treatment.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

In consideration for the services to be rendered to the above name client, I hereby promise to pay for those services in accordance with the rates and terms now in effect at the Child and Family Guidance Centers, to the extent I am legally responsible for such payment. I hereby assign to the Centers any and all benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. I acknowledge that any balance not covered or paid by such policy or plan, not covered by Medicaid, Medicare or Worker's Compensation is my legal responsibility.

IF I AM A MEDICAID PATIENT

I understand that, in the opinion of the Centers, the services that I have requested to be provided to the above named client on this date may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health-insuring agent determines the medical necessity of the services that I request and receive. I also understand that I am responsible for payment of the services I request and receive if these services are determined not to be reasonable and medically necessary for my care. I understand that if I do not have insurance financial assistance may be available through a Sliding Scale Co-payment, if I meet the eligibility requirements and provide verification of my income.

PATIENT RIGHTS AND COMPLAINT PROCEDURES

I hereby acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint I might have.

This is a legal consent and assignment of benefits form. Read it carefully and ask any questions you may have prior to signing it. This consent is valid for only twelve (12) months and must be renewed annually if services continue.

Signature of Client (if not a minor) or Legal Guardian(s) | Date

Printed name of Client or Legal Guardian(s) | Signature of CFGC Staff

Relationship(s) to Client | Printed name of CFGC Staff

Picture ID Verified | Type of ID | Date

GUARANTY

I hereby guarantee payment of the account of the above named client. I further agree to pay in full the charge due at the beginning of each session unless other arrangements have been agreed to by CFGC in writing. I have been told the amount due per session, and understand that this amount covers only the charge for each therapy session and does not include any other services or activities.

Signature of Guarantor | Street Address

Name Printed | City/State/Zip

Authorization For Use and Disclosure of Protected Health Information

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I hereby authorize the use or disclosure of my individually identifiable Protected Health Information (PHI) as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive my PHI is not a health plan or a health care provider federal privacy laws may no longer protect my PHI.

Individual's name: _____ ID Number: _____

Persons/Organizations authorized to release my PHI: Child and Family Guidance Centers (CFGC)

Other Persons/Organizations authorized to receive my PHI:

- ☐ All Physicians Who Have Treated the Above-Named Patient
- ☐ Specific Physicians Who Have Treated the Above-Named Patient (Name/Address/Phone):_____
  _____
- ☐ School District: _____
- ☐ LTSS (Long Term Support Services)-referral system used by the State of Texas to connect people with services based on needs identified through required assessment(s)

Specific description of PHI requested (including date(s): _____

_____

The individual or the individual's representative must read and initial the following statements:

1. I understand that this authorization will expire 12 months from the date below. **Initials:** _____

2. I understand that I may revoke this authorization at any time by notifying CFGC in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions CFGC took in reliance upon my authorization before it received my revocation. **Initials:** _____

   You may revoke this authorization by signing a Revocation of Authorization form and returning it to CFGC. To request a Revocation of Authorization form, you may contact: Child and Family Guidance Center, 8915 Harry Hines, Dallas, TX 75235 (214-351-3490).

SECTION B: MUST BE COMPLETED WHEN CFGC REQUESTS THE AUTHORIZATION FOR IT'S OWN USE OR FOR ANOTHER COVERED ENTITY TO DISCLOSE PHI TO CFGC FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION PURPOSES

To be completed by CFGC Staff:

1. The specific purpose of the use/disclosure of my PHI is: _____
   (CFGC will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.)

NOTICE TO PATIENT: Except in cases of clinical trials, treatment, payment for services or any other exception stated in the HIPAA Privacy Notice, we will be dependant upon authorization for the requested use or disclosure of your PHI. You or your representative has the right to refuse to sign this authorization. You or your representative may also inspect and/or copy the health information in accordance with CFGC policies.

SECTION C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

_____ _____

Individual's Name *(Please Print)* **Social Security Number**

_____ _____

Name of Individual's Representative *(Please Print)* **Date**

_____

Description of Representative's Relationship or Authority to Act on Behalf of Individual

_____ _____

Signature of Individual or Individual's Representative **Date**

VERIFICATION OF RECEIPT OF RIGHTS

I have received a copy of my rights as a person receiving service or as a legal representative of a person receiving services from Child and Family Guidance Center. My signature means that these rights have been explained to me in simple non-technical language, that all questions have been answered to my satisfaction, and I understand my rights. **This verification is valid for as long as I am a client at Child and Family Guidance Center unless information has changed in which an updated copy will be provided to me.** At that time a new verification form will need to be completed by myself or my legal representative.

Person receiving services or legal representative will initial each applicable form to indicate receipt of rights.

VERBAL	WRITTEN	N/A	
_____	_____	_____	**Consent for Service / Financial Agreement**
_____	_____	_____	**Clients' Rights / Grievance Procedure**
_____	_____	_____	**Notice of Privacy Practices**
_____	_____	_____	**Authorization for Use & Disclosure PHI**

_____ _____
Signature of Person Receiving Services Date

_____ _____
Signature of Parent/ Guardian/Managing Conservator (if applicable) Date

_____ _____
Signature of Staff Verifying Receipt of Rights Date

_____ _____
Signature of Witness (if person is unable or unwilling to sign) Date

child & family
guidance center

Consent to Participate in Telehealth Care

Client Name: _____ Medical Record #:_____

Date of Birth: _____

1. I hereby voluntarily consent to participate in the Child & Family Guidance Center telehealth services, whereby I will be receiving mental health services via videoconferencing technology.

2. I have been informed as to how the video conferencing technology will be used to affect my care. I understand that this care will not be the same as a face-to-face patient/mental healthcare provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand that there are potential risks associated with this technology, including but not limited to interruptions, lack of audio or video, unauthorized access, and technical difficulties. I understand that my mental healthcare provider(s), or I, can discontinue the telehealth consultation/visit if one of us feels that the videoconferencing connections are not adequate for the situation.

4. I understand that during my telehealth session, there will be an extender available to me, at my location, in the event that I have any questions or concerns before, during, or after the session.

5. I understand that at any time, if either my mental healthcare provider or I decide that telehealth services is not the appropriate type of care for me, then either my mental healthcare provider or I can terminate the telehealth services. I understand that if my mental healthcare provider feels that a face-to-face appointment is necessary, I will be asked to schedule any future appointments in the clinic of my choice and/or provide me with an internal referral to another provider.

6. I understand that my express consent is required to release any healthcare information, including but not limited to that information relating to testing, diagnosis, or treatment for psychiatric disorders/mental health, drug or alcohol abuse/use, HIV (AIDS virus), or sexually transmitted diseases. Should I choose to release any information to outside entities, I will do so through the standard Release of Information form provided by Child & Family Guidance Center.

7. I understand others may also be present during the session other than my mental healthcare provider for the facilitation of care, or for the facilitation of the telehealth technology. The above mentioned persons will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request that non-medical/clinical personnel leave the telemedicine session.

8. I understand that for the session, I am to make myself available a few minutes prior to the appointment and ensure I am in a private setting away from distractions. I further understand that the recording and posting of sessions on any social media platform is prohibited.

9. For sessions with medical personnel only: I've had the alternatives to telehealth explained to me, and in choosing to participate in a telehealth session, I understand that some parts of the session involving physical tests or laboratory evaluations may be conducted by individuals at my location, at the direction of my health care provider.

10. I agree that these telehealth encounters may result in my Protected Health Information (PHI) being retained and used, as described by federal HIPAA (Health Insurance Portability & Accountability Act) regulations, and those various HIPAA regulations pertaining to this PHI may become applicable. I understand that Child and Family Guidance Center shall operate in accordance with all HIPAA provisions, as well as all applicable federal, state, and local laws. The interactive tele-video equipment and telecommunication lines used in session are HIPAA approved for patient security and privacy/

11. I understand that I can revoke this consent at any time, in writing via the Revocation of Authorization form. I understand that a record of this revocation shall be maintained in my medical record. In the event that I choose to revoke this consent, I understand that I may not be able to continue with my testing, diagnosis, or treatment.

12. I have read this document carefully, or have had it read to me, and understand the risks and benefits of the teleconferencing session and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described.

This consent will remain in effect for 12 months from the date signed or revoked by me in writing, whichever occurs first.

By:_____ OR _____

Patient/Representative Signature Guardian or Legal Representative

_____ _____

Date Date