THE CARRUTH CENTER
AT THE PARISH SCHOOL

THE PARISH SCHOOL

Consent for Treatment – Telehealth

Child's Name: _____

The Texas Board of Examiners of Professional Counselors recognizes telepractice (the act of providing Telehealth services) as a means for clients to receive needed mental health services. Mental health services delivered by telehealth must follow applicable federal and State of Texas privacy laws and be in accordance with State of Texas mental health provider practice requirements.

For your child to receive mental health services via teletherapy, please initial each item below and sign and date the bottom of this form.

_____ I hereby consent to engage in teletherapy with The Parish School/The Carruth Center for therapeutic service for my child. I understand all other aspects of services (billing, cost, privacy, authorization for emergencies) remain in effect. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment, however I will remain financially responsible for services rendered before consent is withdrawn. I understand that if I withdraw or withhold consent, equivalent in-person services might not be available at the same location or time as teletherapy services.

_____ I understand that an adult facilitator must be available in order to assist the child with technical difficulties or to keep the child on task during the teletherapy session. This facilitator can be a parent or other caregiver that the parent designates.

_____ I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my child's medical information, both orally and visually.

_____ The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential and subject to the same laws and protections as apply to in person therapy.

_____ I understand that there are risks and consequences from teletherapy, including, but not limited to the possibility, despite reasonable efforts on the part of The Parish School/The Carruth Center in compliance with applicable law, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. If a disruption or distortion or other technical difficulties, I understand that my session may be termination and rescheduled. I understand that I may expect the anticipated benefits such as improved access to

care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

_____ The Parish School/The Carruth Center currently uses Zoom to provide teletherapy services. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my child's teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my child's teletherapy session.

_____ I understand that if I have a complaint or grievance in regards to the provision or receipt of teletherapy services, I should contact The Parish School at businessoffice@parishschool.org or The Carruth Center's Clinic Director, Mimi Branham, at mbranham@carruthcenter.org. I understand that The Parish School and/or The Carruth Center will review, investigate, and respond to any such complaints.

_____ I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the teletherapy session and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the room; and/or (3) terminate the consultation at any time.

I have read, understand and agree to the information provided above. I have been given the opportunity to ask questions about the appropriateness of telehealth for my child and have any questions about teletherapy services answered. I hereby give my informed consent to participate in the use of teletherapy services for treatment under the terms described herein.

_____ _____

Signature of Parent Date