The Steven A. Cohen Military Family Clinic at Easterseals

Informed Consent

I understand that the Steven A. Cohen Military Family Clinic at Easterseals (SACMFC-ES) provides individual, family and couple's counseling in an in clinic outpatient environment or by telemental health (TMH).

I understand that information related to the sessions are confidential; neither the clinician nor the SACMFC-ES will disclose any information about my treatment or therapy without my written permission, except as may be allowed or required by law. The HIPAA Notice of Privacy Practices provides you with additional information regarding the confidentiality of your records. If utilizing TMH, I will be videoconferencing with my clinician through the Zoom platform. Only my clinician and I will be able to view the videoconferencing via the link provided to me by my clinician. The videoconference will not be recorded at any time during my care.

I am aware that regular email or text messaging is not a secure and confidential means of communication. If I or my family emails or sends a text message to a clinician or other team member, confidentiality cannot be guaranteed.

My right to confidentiality may be waived under the following circumstances:

1. If there is an imminent threat or harm to myself or others,
2. There is an indication of abuse of a child, disabled/dependent adult or elderly adult,
3. As required for record-keeping, reporting or auditing purposes,
4. If properly requested by court subpoena or law enforcement agency, or
5. When allowed for public health reporting.

These situations and other circumstances and rights related to my protected health information have been explained to me in more detail in the copy of the SACMFC-ES HIPAA Notice of Privacy Practices provided to me.

For therapy, my first appointment/session will be an initial assessment and therapy will begin with the second appointment/session. My clinician will discuss therapy goals with me at that time. If for any reason I leave or I am discharged from the SACMFC-ES, my clinician will provide appropriate referrals to other therapists or agencies if needed at the time of discharge.

I understand that I have rights as a client, including the right to be provided with professional, respectful and care. I also have the right to equal consideration and treatment regardless of sex, race, religion, color, economic status or sexual preference.

I understand that I have the right to have an explanation of my treatment plan and diagnosis.

I have the right to request to see or receive a copy of my records though SACMFC-ES can refuse my request, if it is deemed not in my best interest.

I have the right to revoke this consent for services in writing at any time, though SACMFC-ES may use the information for which I gave consent for them to share in the manner explained in the HIPAA Notice of Privacy Practices.

In the event that I make a request that SACMFC-ES declines to honor, I may have the right to make an appeal or complaint in the manner outlined in SACMFC-ES' policies.

Risks and Benefits

I understand that there are risks and benefits which may occur in any mental health setting. Therapy may involve the risk of remembering unpleasant events and may arouse strong emotional feelings, such as sadness, loss or anxiety. Therapy can impact or change relationships with significant others. Though benefits of therapy cannot be guaranteed, many studies show benefits for those who pursue psychotherapy. These benefits may include an improvement in mental health conditions such as depression, anxiety or post-traumatic stress disorder; improved ability to relate to others; improved cognitive processing; a clearer understanding of self, relationships, values, goals and an enhanced ability to deal with stress. Taking personal responsibility for working on identified issues may lead to greater personal growth.

I understand if utilizing TMH that downloading the videoconferencing software may affect the performance or operation of my personal computer, tablet, phone, and/or internet service. Should I notice a change in the performance of my personal device that I use for my Cohen Clinic videoconferences, which I believe could be related to the videoconferencing software, I understand my clinician is available to help troubleshoot the problem. If necessary, my clinician can advise me on how to remove the software from my computer. I understand the clinician is not able to provide on-site technical support in my home and is not responsible for technical issues. While TMH is a valuable therapy approach, in some limited cases there may be the following limitations:

1. Ability to misunderstand or miscommunicate information and body language due to impaired visual and/or auditory functions during session
2. Disruption in service and/or connection during the TMH session interrupting normal flow of personal interaction
3. Ability to feel disconnected to or not understood by the providing clinician due to physical separation at time of care

Consent to Release Information to Payors

I agree that by signing below, SACMFC-ES may disclose information related to my treatment to my insurance company or another entity that is responsible for paying for these services. I understand that SACMFC-ES may make such a disclosure to receive payment for the services provided to me. I understand that in doing so, SACMFC-ES will only disclose information necessary for payment purposes. I also understand I can revoke this part of the consent for release of my treatment information to my insurance company or other payor at any time. However, I understand that my revocation will not be effective for information already released, and that once I have revoked this consent, my insurance company will no longer pay for services I have received.

Signature

This consent of services and release of information as described above will expire 365 days from the date of my signature below.

My treatment by SACMFC-ES is conditional upon signing this consent.

_____	_____
Client Signature (or Legally Authorized Representative)	Date
_____	_____
Client Printed Name (or Legally Authorized Representative)	Relationship to minor (if applicable)
_____	_____
Printed Minor Name	DOB of Minor
_____	_____
Clinic Staff Signature	Date

_____

Print Name