Consent to treat by Online Counseling

The Family Healing Center, Inc

I ____________ (Name of Patient/Client) whose DOB is___________. I authorize The Family Healing Center, Inc. to provide treatment services on-line. I agree to have my substance abuse and/or mental health session on-line by internet. I understand that The Family Healing Center, Inc will protect confidentiality while in session. All sessions will contain from one to five persons, depending on the type of treatment that I have been referred for. However, I do understand the risk(s) of internet service. My treatment service will be on-line as long as the regulations and policies for COVDI-19 are in place. The information and or services that may be disclosed on-line may include the following that are checked:

___Assessment
___Diagnosis
___Treatment Plan
___ Presence/Participation in TX
___Demographic Information
____ Education Information
____Continuing Care Plan
____Progress Notes
____Progress in Treatment
____ Termination

Revocation:
I understand that I have the right to revoke, in writing, at any time by sending written notification to The Family Healing Center, Inc. * The Blair Building * 241 East Main Street * Morehead, KY 40351

Expectation:
Unless sooner revoked, this authorization expires on the following date: ______________ or as otherwise indicated: _________________________'
Disclosure of Information on-line.
I understand that The Family Healing Center, Inc. is responsible for the confidentiality of my session(s) and my file. However, I do understand that there could be minimum risk of on-line services.

____
Signature or Patient/Client Date

____
Signature of Guardian or Guardian Date

_______Check here if the client refuses to sign authorization

____
Signature of Staff/Witness Date