Kascel Therapy LLC

Phone: 386-585-5955 Email: jmbaker@kaseltherapy.org Fax: 386-585-7017

Tele-Health Consent for Therapy Services

Client Name:	**DOB:**
Parent Name:	
Address:	
Phone:	

I hereby consent to using live videoconferencing services provided by Kascel Therapy, LLC as an option for receiving Therapy intervention for my child. I understand that these services may involve the communication of my child's health information, both orally and visually. Specifically, I understand that videoconferencing services include, but are not limited to consultation, treatment, and transfer of health data using interactive audio, video, or data communication.

I further understand the following with respect to use of Kascel Therapy's videoconferencing services:

1. **I have the right to withhold or withdraw consent at any time without affecting any right to further care or treatment, not risking the loss or withdrawal of any program benefits to which my child would otherwise be entitled.**
2. **The laws that protect the confidentiality of my child's health information may also apply to these services. As such, I understand that the information disclosed by me during any videoconferencing sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality.**

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3. **There are risks and consequences from use of these services, including but not limited to the possibility, despite reasonable efforts on the part of Kascel Therapy, LLC that the transmission of my child's health information could be disrupted or distorted by technical failure, and/or the transmission of any health information could be intercepted or accessed by unauthorized personnel.**
4. **I have the right to access my child's health information and copies of health records in accordance with HIPPA privacy rules and applicable state law.**

I have read and understand the information provided above. I have discussed it with representatives from Kascel Therapy, LLC, and all of my questions have been answered to my satisfaction.

Signature of parent/guardian:	**Date:**
Relationship to client:	
Signature of Kascel Therapy representative:	**Date:**