SAINT LOUIS COUNSELING
IMPROVING LIVES SINCE 1955

SCHOOL PARTNERSHIP PROGRAM (SPP)
9200 Watson Rd., G-101
St. Louis, MO 63126-1528
P: 314.544.3800 **F:** 314.843.0552

(rev 8-1-2020)

Consent Form: Parent/Guardian

Note: Please read and sign all three sections.

I give permission for my child _____

to participate in counseling services with Saint Louis Counseling' school counselor.

Counseling services will be provided at _____ School.

Parent/Guardian's Name (Please Print) _____

Parent/Guardian's Signature_____

Phone Numbers: _____

_____

Best Time to Contact: _____

Today's Date: _____

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I give permission for the therapist to speak with and/or write to the principal, or other referring school personnel for the purpose of sharing information that will help the school staff understand and work with my child. This consent will remain in effect until counseling is terminated.

Parent/Guardian's Signature _____

Today's Date_____

Some case records may be used for auditing purposes. All records will be kept in strictest confidence, however.

United Way
United Way of Greater St. Louis

Catholic Charities FEDERATED AGENCY

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Telehealth Informed Consent

Client Name:_____ Clinician:_____

Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio-video or telephone communication. I hereby consent to participating in psychotherapy via audio-video communication (referred to as "Telehealth" below.)

I understand I have the following rights under this Agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make toward a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. My clinician and I will establish an emergency plan and protocol for contact in between sessions. This will be established before the start of treatment, and I can request a copy of these protocols in writing. Further, I understand that the dissemination of any personally identifiable images or information from Telehealth interaction to any other entities shall not occur without my written consent.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, it may be recommended that I come into the office for sessions.

Saint Louis Counseling clinicians use Zoom to conduct telehealth sessions, in addition to telephones. Clinicians do not download any client PHI (personal health information) onto their computers, phones, or tablets, and are trained and are current in HIPAA compliance. In order to use Zoom, Saint Louis Counseling must have an accurate email address for you on file. Please add it on the back of this form.

I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I agree to obtain the necessary authorizations to receive services. I agree to pay the fee, co-payment, and deductible and understand that payment is expected at the time services are rendered. I agree to pay the fee, co-payment, and insurance amount for non-emergency cancellations with less than a 24-hour notice. I give permission to Saint Louis Counseling to bill my insurance company and to receive payment for services. I understand that I remain personally responsible for payment of services provided.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Saint Louis Counseling. My signature below indicates that I have read this Agreement and agree to its terms.

Information for Zoom or Phone Telehealth

Email for Zoom: _____

Best phone number for phone and billing purposes: _____

_____ _____
Signature of Client / Legal Guardian Date

_____ _____
Relationship to Client Date

_____ _____
Clinician Signature Date