Spence Counseling Center PC
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Consent to Treatment, Use, and Disclose Your Health Information

This form is an agreement between you, _____(***client name***) and me/us Spence Counseling Center, P.C. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____ (***minor child***).

When we examine, diagnosis, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use this information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent.

If you do not sign this Consent Form agreeing to it and what is in our Notice of Privacy Practices, we cannot treat you as permitted by Section 164.506 of the Code of Federal Regulations.

_____ Initials

Telehealth Session Consent

Spence Counseling Center will be using Zoom for video and web-based telecommunications with our clients. Zoom is a HIPAA compliant, encrypted platform that is secure and private for therapy sessions. This service is being offered as alternative to an in-person session. The session will be conducted between yourself and any other party you choose to be present during the session in a virtual room. The session will be conducted on a phone, computer, or i-pad and both parties will need to have cellular or internet connectivity. Your therapist will send you a link by e-mail or text ahead of time to join the session meeting.

You will need to disclose to your therapist your current location and any other parties including their role that will be participating in the telehealth session. There are potential risks to this technology, including interruptions, unauthorized access, or technical difficulties. I also understand that my therapist or I can discontinue the telehealth session if it is felt the video conferencing connections are not adequate. I also understand that I can discontinue the telehealth session at any time. Therefore, I give consent to conduct telehealth sessions with my therapist.

_____ Initials

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important information. This Notice is a shortened version of the full legally required Notice of Privacy Practices (NPP) which is available in the office, so refer to the Complete Notice for more information. Even in the Complete Notice, we can't cover all possible situations, so please talk to your provider or our Privacy Officer, Rhonda Spence about any questions or problems.

We reserve the right to change our Consent Form and Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations and clients will be notified if we change them. You are always welcome to a copy of our Consent or Notice of Privacy Practices in paper or electronic form. If you are concerned about some of your information, you have the right to ask us. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your written request. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ Initials

_____	_____	_____
Client/Guardian Signature	**Print Name**	**Date Signed**