Lutheran Services Florida CINS/FINS
Informed Consent for Tele-Visits

Client: _____ D.O.B._____ SSN: _____

I,_____, hereby voluntarily consent to engage in tele-visits. Tele-visits are a form of counseling provided via internet technology, which can include consultation, treatment, transfer of protected health information, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that tele-visits involve the communication of my medical/mental health information, both orally and/or visually.

Limitations on Confidentiality
Tele-visits have the same purpose or intention as counseling sessions that are conducted in person. However, due to the nature of the technology used, I understand that tele-visits may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to tele-visits:

Client's Rights, Risks, and Responsibilities:

1. I, the client/legal guardian of client, need to be a resident of Florida.
2. I, the client/legal guardian of client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to tele-visits. As such, I understand that the information disclosed by me during the course of my counseling session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I signed when beginning services with Lutheran Services Florida.
4. I understand that there are risks and consequences of participating in tele-visits, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my counselor, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems. In addition, I understand that tele-visit based services and care may not be as complete as face-to-face services.
6. I understand that I may benefit from tele-visits, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of counseling, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
7. I accept that tele-visits do not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in tele-visits. I am responsible for:
    - Providing the necessary computer, telecommunications equipment and internet access for my tele-visit sessions.

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- Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele-visit session.
- It is the responsibility of the treatment provider to do the same on their end.

Duration of Consent
I understand my consent for treatment is freely given and may be withdrawn at any time. In cases of shared parental custody for treatment on a minor, I understand it is the right and responsibility of the custodial parent to advise the non-custodial parent of the child's treatment and the non-custodial parent has the right to withdraw consent at any time.

Legal Guardian (if child is client)
I,_____, do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my legal consent to the treatment and services mentioned in this form.

_____ _____
Client/Guardian Date

_____ _____
Witness Signature Date