Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

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Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

CONSENT TO PROVIDE TELEMENTAL HEALTH SERVICES:

I/We understand that telemental health is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent for providing health care services to me via telemental health by:(clinician's name)_____.

I/We understand that the laws that protect privacy and the confidentiality of medical information also apply to telemental health. As always, your insurance carrier will have access to your medical records for quality review/audit.

I/We understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I/We understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Therapy Place, Inc. at 712-254-9018. As long as this consent is in force, mental health services may be provided to me via telemental health without the need for me to sign another consent form.

No information identifying you or your family will be released or disclosed without written consent by you or a parent or your legally designated representative. You may be asked to sign specific releases of information to any other individuals or agencies which Therapy Place staff deem important to communicate with, in the best interests of you and/or your family. Therapy Place will not knowingly utilize any treatment or procedure which is experimental, controversial, or carries an intrinsic risk. You have the right to ask questions about any procedures used during therapy.

Any grievance concerning the quality of services provided by Therapy Place should be made in writing to the President of Therapy Place, Inc. A review of the grievance will take place within thirty days.

This agreement was entered into and signed on the _____ day of _____

on behalf of _____ by:

_____ _____
(Client signature or Parent if client under the age of 18) (Relationship to client)

_____ _____
(Date) (Client email address)

_____ _____
(Witness to signature) (Client phone number)

Email Address:_____

This agreement will remain in effect until one year after the family's/individual's involvement with Therapy Place, Inc. has been discharged. *Signature(s) indicate the form was read, understood, and agreed on by the client/parent/guardian.