



**Awakenings**  
Christian Counseling

4250 S. Westnedge Kalamazoo MI 49008  
Email: counsel@awakeningscc.com Phone: 269-234-2343

**Telehealth Consent Form**

Client Name: \_\_\_\_\_

I agree to receive my outpatient behavioral health services through Telehealth. I understand that the behavioral health care provider is located in an alternate approved location.

A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. Awakenings Christian Counseling telehealth service uses a secure web-based system (Doxy.me) for transmitting audio and video data. To ensure privacy, the data is encrypted at the highest level available for telehealth.

This consent is valid for one year for follow-up telehealth services with the health care provider.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telehealth service. The same confidentiality protections that apply to my other behavioral health care and consents also apply to the telehealth service.
- I will have access to all behavioral health treatment information resulting from the telehealth service as provided by law and according to the existing Awakenings Christian Counseling confidentiality policies.
- The information from the telehealth service cannot be released to anyone else without my additional written consent.
- Client will be in a private room and secure site for all sessions as will the therapist.
- I may exclude / include anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises and if needed (211) or (911) services including duty to warn may be needed if counselor deems necessary if observed during the telehealth session.
- If I decline the telehealth services, the other options/alternatives available for me include in-person meetings only.

I have read this document carefully, and my questions have been answered to my satisfaction.

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date \_\_\_\_\_