



TRINITY CHRISTIAN COUNSELING
36405 Harper Avenue
Clinton Township, MI 48035
586-468-0401 Fax: 586-463-2389
counseling@trinityct.org
www.trinityct.org/counseling

CONSENT FOR TELEHEALTH CONSULTATION


1. I wish to engage in a telehealth consultation with my health care provider.
2. My health care provider explained to me how the telephone or video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the telehealth connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I understand that if my insurance will not cover my sessions with any provider from Trinity Christian Counseling that I will be responsible for any payment in full at time of session.

Printed Name: _____

Date: _____

Signature:  _____