RESTORING YOU WELLNESS CENTER, LLC

1113 S. Main Street, Ste F, Cheshire, CT 06410

Client Demographic

Name: _____ Insurance: _____ Member ID:_____DOB:_____
Phone #:_____

Consent and Acknowledgment Form

In Order to Protect Your Privacy:

The staff of RYWC is required by law and professional ethics to maintain client confidentiality. Federal confidentiality laws and regulations prohibit RYWC from complying with any request for information or to acknowledge if an individual is or ever was a client of RYWC unless the client or guardian provides a written release with the following exceptions:

- A client is suicidal or homicidal
- If there is a suspicion of physical, emotional, sexual abuse or neglect involving a child under 18 we are mandated by law to report suspicions to the Department of Children and Families (DCF) under Connecticut General Statute 17a-101. We are also mandated to report, to the State of Connecticut, suspicion of abuse or neglect of an adult over 65, or anyone who is disabled.
- A court order, or a subpoena with written authorization from the client.
- Cases reviewed by the State for licensing purposes.

It is the policy of RYWC to use and disclose protected health information for treatment, payment, and health care operations reasons only with the written consent and acknowledgement of receipt of RYWC's Notice of Privacy Practices by the client or parent/guardian, unless the use or disclosure is required to be made by law without such consent or acknowledgment. I also understand that there are risks and consequences associated with telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur. In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service.

Treatment Planning Goals: □ Housing □ Mood Regulation □ Coping with Physical Health □ Parenting □ Communication skills □ Trauma □ School/Work □Depression □Anxiety □Divorce □Foster Care □Sibling Conflict □Financial Stability □Other:

_____

I consent to the use or disclosure of my/my child's protected health information as described above. I hereby consent to engage in telehealth (e.g., internet or telephone-based therapy) as a potential venue for my psychotherapy treatment. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that further information regarding how RYWC may use or disclose information can be found in RYWC's Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received RYWC's Notice of Privacy Practices currently in effect.

Print Name of Client	Date	Print Name of Parent/Guardian

Signature of Client or Parent/Guardian