Jacksonville Children's and Multispecialty Clinic, P.A.

Behavioral and Mental Health

I affirm that I, _____, am the (**CIRCLE ONE**): PATIENT/ PARENT/ LEGAL GAURDIAN, the responsible party and I hereby authorize and give permission to the staff of **Jacksonville Children's Multispecialty Clinic (JCMC)** to render treatment and/or services to myself and/or the patient, _____. I understand that I can withdraw consent to treatment at any time and that a withdrawal of treatment must be done in writing and will include reason(s) for withdrawal. I understand the practice of medicine, psychiatry and other mental health disciplines are not an exact science and I acknowledge that there have been no guarantees made to me concerning my care. If I choose to seek psychotherapy (counseling) services with a counselor at JCMC, I understand that psychotherapy is a cooperative effort between patient and therapist, therefore I will not hold JCMC or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws require my psychiatrist/psychologist/therapist to report all cases in which there exists a specific potential harm to others in cases of reported or suspected physical, sexual and/or neglect of children. Dr. Ahlberg's treatments are for medical purposes only and are not suitable for forensic purposes.

TELEMEDICINE: I understand that my health care provider may want me to engage in telemedicine consultations. I understand that such a consultation will not be a direct patient / health care provider visit and that I will not be in the same room as my health care provider. My health care provider has explained to me how the video conferencing will be used. I understand that my PHI (Personal Health Care Information) may be shared with other individuals for scheduling and billing purposes. I understand that my health care provider has assistants that will be present during the consultation. I understand that everyone involved in the video conferencing process will maintain confidentiality of any information obtained. I understand that there are potential risks to this technology to include: interruptions, unauthorized access and technical difficulties. If the electronic connection becomes compromised or inadequate for any reason, I understand that either I or my health care provider may discontinue the telemedicine consult/visit.

IMPORTANT: The use of ANY electronic device used for taking pictures or recordings is prohibited by Patient Privacy Rules. Failure to follow these rules may result in your appointment being canceled and/or may result in termination from the practice.

_____ _____

SIGNATURE OF PATIENT /PARENT / LEGAL GUARDIAN DATE

_____ _____

Patient Name Date of Birth

ACTIVE DUTY TRICARE ONLY: By receiving psychiatric services at JCMC/JBMH, I understand that any records created will be available to my Military Treatment Facility, **with or without** my consent. With this understanding, I elect to continue with this appointment by signing below.

_____ _____

SIGNATURE OF ACTIVE DUTY MEMBER DATE