SETTING & DELIVERY CONSENT TEMPLATES

Telehealth Consent

A separate consent from the general consent to treat in most states. Shown only when telehealth is on the service list.

Client name _____ **Date of birth** _____

WHAT TELEHEALTH MEANS HERE

Some services for the client named above may be delivered by live video rather than in person — typically caregiver coaching, supervision, and assessment activities that can be conducted remotely. The clinician and the client are in different locations and communicate through a video platform.

WHAT YOU SHOULD UNDERSTAND

- The same privacy protections apply to a telehealth session as to an in-person session.
- Technology can fail. If a connection drops, we will reach you at [PHONE] and reschedule or continue by another method.
- Video is not appropriate for every service or every session, and your clinician may recommend returning to in-person delivery.
- You may decline telehealth or stop it at any time without affecting your access to in-person services.
- Your health plan may cover telehealth differently from in-person services, and coverage rules change.
- You are responsible for finding a private space for the session and for your own internet connection.

LOCATION AND EMERGENCIES

I will tell my clinician where the client is physically located at the start of each session, and I understand this is required because licensure and coverage depend on it. I will provide a phone number where I can be reached during sessions and the address where the client will be, so that emergency services can be directed there if needed.

- ☐ I consent to services delivered by telehealth.
- ☐ I decline telehealth and request in-person services only.

Parent / guardian signature	Printed name	Date
Relationship to client	Phone	Email

SETTING & DELIVERY CONSENT TEMPLATES

Photo, Video & Recording Release

Separate opt-ins, never a condition of starting. Recording for clinical supervision is a different question from recording for marketing.

Client name _____ **Date of birth** _____

PERMISSION BY USE — INITIAL EACH ONE YOU ALLOW

- ☐ Recording sessions for clinical review and supervision by the treating team
- ☐ Recording for training internal staff, with identifying details limited to what training requires
- ☐ Photographs or video used in materials shown outside the practice, including on our website or social media
- ☐ Use of the client's first name in materials shown outside the practice
- ☐ Recording of telehealth sessions

TERMS

I understand that permission is separate for each use above and that declining any of them will not affect the client's services in any way. Recordings made for clinical review are stored under [PRACTICE NAME]'s records policy and retained for [PERIOD].

I may revoke this release at any time in writing. Revocation applies going forward and does not reach materials already published or distributed.

Parent / guardian signature	Printed name	Date
Relationship to client	Phone	Email

SETTING & DELIVERY CONSENT TEMPLATES

In-Home Services Safety & Access Agreement

In-home families only. Collected before the first visit, not after the technician arrives.

Client name _____

Service address _____

Parent / guardian _____

Phone _____

ACCESS

Entrance and parking instructions _____

Building or gate code _____

Adult present during sessions _____

Backup contact if no one answers _____

THE HOME ENVIRONMENT

- ☐ There are animals in the home. Type and arrangements: _____
- ☐ Someone smokes in the home during the hours sessions would occur.
- ☐ There are firearms in the home. I confirm they are stored locked and unloaded, separate from ammunition.
- ☐ Other adults or children are regularly present during session hours.
- ☐ A working smoke detector is present on the service floor.

AGREEMENTS

- A parent or another responsible adult will remain in the home for the whole session.
- A safe, reasonably quiet workspace will be available, with the television off during session time.
- Sessions may be ended early if conditions in the home make it unsafe to continue, and we will work with you before that affects the schedule.
- Session start and end may be verified electronically at the service location, as required for home and community services.

Parent / guardian signature _____ Printed name _____ Date _____

Relationship to client _____ Phone _____ Email _____

SETTING & DELIVERY CONSENT TEMPLATES

Community Outing Permission

Community-based programming only. One standing permission, refreshed on the cadence you set.

Client name _____ **Date of birth** _____

PERMISSION

I give permission for the client named above to take part in community-based sessions with [PRACTICE NAME] staff, at locations relevant to the treatment goals in the current plan — for example a store, park, library, or restaurant within [DISTANCE] of the service address.

TRANSPORTATION

- ☐ The client will be transported by a parent or guardian to and from community sessions.
- ☐ The client may be transported by [PRACTICE NAME] staff in a practice vehicle.
- ☐ The client may not be transported by staff under any circumstances.

TERMS

I understand community sessions carry ordinary public-setting risks, that staff will maintain the supervision level described in the treatment plan, and that I will be contacted at [PHONE] if a session ends early. This permission is effective from [DATE] and is reviewed at least every [PERIOD].

Parent / guardian signature	Printed name	Date
Relationship to client	Phone	Email