SAINT LOUIS COUNSELING
A MINISTRY OF CATHOLIC CHARITIES

Consent to Treatment Form

Confidentiality:
I understand that the services provided to me by Saint Louis Counseling are confidential and will not be disclosed, except as provided by law.

Release of Information:
I hereby authorize Saint Louis Counseling to release information necessary for billing, financial or chart audits, quality assurance reviews, and for collection of nonpayment of charges. This release will be valid until I am no longer receiving care, treatment, and/or services and my account is settled.

Use of Telehealth

- *General Information:* Telehealth requires transmission, via Internet or tele-communication device, of health information and communications. By agreeing to use the telehealth/telemedicine services, I understand and expressly consent to obtaining, using, storing, and disseminating to necessary third parties, protected health information about me, including my image, as necessary to provide the telehealth services.
    - I understand it is necessary that I share my Location with my provider, and that it is my obligation to notify other persons in the location, either on or off camera and who can hear or see the session.
    - I agree that I will not record either through audio or video any of the session, unless I notify my provider, and this is agreed upon.
- *Benefits of Telehealth*: The utilization of Telehealth allows the patient and clinician to engage in services without being in the same physical location. I understand that provides the following benefits:
- Easier access to care;
- Makes care more convenient and take less time;
- Provides more efficient medical evaluation and management in many situations.
- *Privacy & Security of Telehealth:* As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of individual identification and imaging data, and they will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I

further understand that the nature of electronic communications technologies is such that there is no guarantee that our communications will be kept confidential, or that other people may not gain access to our communications.
    - Even with the use of updated encryption methods, firewalls, and back-up systems to help keep information private, there is a risk that electronic communications may be compromised, unsecured, or accessed by others. I agree to take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth). I further agree to take reasonable steps to find a private place for our sessions/services where there will be no interruptions, and to protect the privacy of sessions/services on my cell phone or other device.
- *Risks & Transparency Related to Telehealth*: I understand there are potential risks to using telehealth technology, including but not limited to interruptions, unauthorized access, and technical difficulties. I further understand that telehealth treatment is different from in-person treatment, and that if my provider believes I would be better served by another form of services, such as in-person treatment, it may be recommended that I come into the office for sessions. I agree that I will disclose the presence of other people at my location before the start of the session, and I understand that my provider will do the same.
- *Your Rights & Opt-Out for Telehealth*: I understand that my participation in Telehealth is voluntary, and that I have the right to opt out from the use of Telehealth in my treatment. I further understand that I have the right to refuse or withdraw my consent to the use of Telehealth in my treatment without affecting my right to future care or treatment. I can ask questions at any time and have the right to receive clear answers about the use of Telehealth in my treatment.

Please initial one of the options below to indicate your choice:

_____ I consent to the use of Telehealth _____ I opt out of the use of Telehealth

Client Rights & Consent to the Use of Artificial Intelligence (AI) for Interacting with Private Health Information

- *General Details about AI Technology*: Artificial Intelligence (AI) technology assists our clinicians in analyzing health data, predicting treatment outcomes, and personalizing your treatment plan. AI systems can process vast amounts of clinical data, including clinical studies, patient histories, and current health parameters, to provide insights that support our healthcare providers in making informed decisions about your care. Your sessions will be transcribed and summarized by HIPAA-compliant technology. The AI tool does not interact with you directly, it merely listens to the conversation and creates a summary. The note it generates is reviewed, edited, and approved by your provider. With your consent, AI can also make a complete recording of your session for use in your care and/or the professional development of your provider.

- *Benefits of AI*: The use of AI technology is intended to improve the efficiency and accuracy of health documentation. It allows the counselor to focus more of their attention on the counseling because it removes the need for taking notes or trying to remember information. It also provides additional clinical insights for the counselor which helps improve outcomes in the treatment process.
- *Privacy and Security Related to AI*: All data used by AI technology is handled in accordance with all applicable state and federal privacy laws, including the Health Insurance and Accountability Act (HIPPA), and our Confidentiality and Security policies. Appropriate safeguards are used to protect PHI against loss, theft, and unauthorized access, disclosure, copying, use, disposal, and modification. Security measures include: 1) Restricting access to PHI to authorized employees who need access in order to carry out their job functions; 2) Training our employees on their privacy obligations and requiring them to sign confidentiality agreements; and 3) Encrypting PHI while at rest and in transit.
- *Risks & Transparency with AI*: There are potential risks associated with AI use. These include, but are not limited to, inadvertent errors in transcription or interpretation of your health information, potential (though highly unlikely) breaches of data security, and unknown bias in the way it generates the session summary and presents clinical information. Please be assured that we have rigorous protocols in place to manage such risks, including your counselor's commitment to review and modify the note as needed using their clinical experience**.**
- *Your Rights & Opt-Out with AI*: Your participation in AI-assisted treatment is voluntary. You have the right to opt out from the use of AI in your treatment, including both the use of AI to generate a summary of your session and/or its use to create a recording of your session for use in the professional development of your healthcare provider. You have the right to refuse or to withdraw your consent to the use of AI in your treatment without affecting your right to future care or treatment. You can ask questions at any time and have the right to clear answers about the use of AI in your treatment. Your provider is ultimately in charge of your care and monitors your AI tools.

Please initial one of the options below to indicate your choice:

_____ I consent to the use of AI _____ I opt out of the use of AI

Informed Consent

I consent to receive care, treatment, and or services at Saint Louis Counseling, a ministry of Catholic Charities. I acknowledge that the benefits, risks, and alternatives to the care, treatment, and/or services being offered have been explained to me. I understand that there is no guarantee that the care, treatment, or services offered will be successful, or help me to achieve the goals I have set for myself.

For Legal Guardians

I consent to my child/dependent receiving care, treatment and/or services, understanding that I have the right to participate in my child/dependent's care, treatment, or services and to speak with my child/dependent's clinician regarding my concerns.

Signature _____ Date Signed_____
Name (printed)_____

Client's Name_____ Client's date of birth_____
Relationship to Client (e.g. legal guardian)_____