Vital Minds Psychiatry, LLC.

<u>Parental Consent for Child's Treatment</u>: Tele-Psychiatry Services

By electronically signing this form, I verify that I understand and voluntarily accept all terms, services, practices, and policies explained in Vital Mind Psychiatry, LLC. Patient Handbook and by my child's provider. I voluntarily consent to psychiatric and/or mental health services provided by Vital Mind Psychiatry, LLC. providers for my child. I understand and accept the scope of services, session structure, cancellation and no-show policy, contact information, and the use of technologies to provide treatment. I also confirm that I understand and voluntarily agree to the following.

1. When using telemedicine services, technical issues could affect a session if there is a poor connection or non-functioning equipment.
2. If I have health insurance, I understand that I am responsible for confirming coverage and network status before my child receives treatment and that I am responsible for payment when services are not covered by my plan.
3. I understand that applicable payment is due at the time of service.
4. I understand that I may ask questions by secure message within the client portal anytime.
5. I understand that I am responsible for privacy related to the technologies that I use to connect with Vital Minds Psychiatry, LLC. services and that I must password-protect those technologies to increase the security of my information.
6. I understand that I must be physically present with my child during all treatment sessions and that I may be responsible for providing information about my child's symptoms when my child cannot provide enough information without my help.
7. I understand that I may be immediately discharged if my child's behavior is a threat to my child's provider(s) or the property of Vital Minds Psychiatry, LLC. Upon such discharge, I understand that I will be given a list of alternate providers in my area from which I may choose a new provider for the continuation of my child's psychiatric care. I understand I am free to choose another provider that is not on the referral list and that I am responsible for making appointments immediately to prevent gaps in my child's care.
8. I understand that I may revoke consent and cancel treatment at will.

Effective Date:

- ❑ BY CLICKING ON THE CHECKBOX, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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