Instructions

1. Please fill out packets and make sure they are signed, witnessed, and positive identification is attached, along with any guardianship paperwork in the case of a minor child who is in foster care or in the company o a legal guardian.
2. Packets can be returned in the following manner, and must be received within 10 days in order to continue services. For clients with packets not returned within 10 days, services will be paused until packet is received.
   a. Mailed to:
      South Shore Behavioral Health Clinic
      C/O Intake
      200 Cordwainer Drive
      Suite 200
      Norwell, MA 02061
   b. Faxed to:
      Attn: Intake
      (339)788-9904
   c. Securely Emailed to intake@ssbhc.com
      Most email servers are not HIPPA compliant, meaning that information sent via email may be susceptible to data breach and or data loss. This method is not recommended, and may be used at client's own liability. For those choosing to email documents, they must be password protected.

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right tofuture care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to to discuss since we may reconnect within ten minutes, please call me at_____ have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
8. South Shore Behavioral Health is providing telemental health services on a temporary basis granted by permission from the Governor of Massachusetts and Massachusetts health insurance companies due to Covid-19. Once these temporary permissions are lifted, all clients wishing to continue services may do so face to face in your home, school, or our office.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

_____

_____

and my emergency contact person's name, address, phone: _____

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian: _____

Date: _____

Signature of witness: _____

Date: _____

Signature of therapist: _____

Date: _____

South Shore Behavioral Health Clinic

Norwell & Lakeville a CARF Accedited Facility

COVID-19 Affidavit and Release of Liability

In our efforts to ensure the safety and wellness of our clients and staff, we want to ensure that those who visit the office (both clients and staff) understand the importance of being healthy and safe. Symptoms of COVID-19 can be mild to severe and can include fever, cough, fatigue, shortness of breath, and digestive symptoms (diarrhea or loss of appetite). Symptoms may appear 2-14 days after exposure. Persons at greater risk include those over the age of 62 or those who have underlying health issues (heart disease, diabetes, respiratory issues, smokers, cancer, or weakened immune system from other underlying causes not listed here).

By signing below, I agree to the following:

1) I understand that I am under no obligation to come into the office.
2) I have not experienced any symptoms of illness including fever, cough, fatigue, shortness of breath, diarrhea, or unexplained loss of appetite in the last 14 days.
3) I have not been ill in the last 14 days.
4) No one in my immediate household have experienced any of the above symptoms or have been ill in the last 14 days.
5) I have not knowingly been exposed to anyone diagnosed with the COVID-19 virus nor currently under quarantine for the virus in the last 14 days.
6) I have not traveled outside of Massachusetts in the last 14 days.
7) If I should begin to feel ill while visiting the office, I will notify a staff member and immediately seek medical help. If diagnosed with COVID-19, I will notify the office so specific steps can be made to quarantine others that may have been affected prior to that diagnosis.
8) I release and hold harmless the South Shore Behavioral Health Clinic (and its staff and clients) of any and all liability if I should develop COVID-19 after visiting the office.

_____ _____

Staff/Client Printed Name Date

_____ _____/_____

Staff/Client Signature Visit time (include approximate start and end time)

_____ _____

Phone Number Email address

_____

Witness