CONSENT FORM FOR TELEHEALTH

*This document represents our agreement to use teletherapy/telehealth as part of your established mental health treatment. It serves as an adjunct to our signed “Informed Consent for Treatment,” whose policies and procedures remain in effect (i.e., limits to confidentiality, maintenance and access to records, fees, billing and payment, arranging appointments, and cancellation policy).*

1. I understand that my therapist and I will engage in teletherapy sessions. I am aware that telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of personal health information using interactive audio, video, or data communications such as the telephone, cellular phones, the internet, and various programs (such as DOXY.ME).
2. My therapist has explained to me how the video conferencing technology (via DOXY.ME) will be used and is in compliance with HIPPA regulations. I am aware that such a session will not be the same as an in-person session, since I will not be in the same location as my therapist.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I am aware that use of technology introduces certain risks to my confidentiality. Risks include, but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be intercepted by unauthorized persons; and/or any electronic storage of my personal information could be accessed by unauthorized persons. I also understand that the programs listed above have their own policies that might interfere with confidentiality, and I am fully aware of the risks associated with working with these programs. I am consenting to treatment understanding that my confidentiality may be limited via telehealth. I also am aware that this therapist will attempt to maintain confidentiality to the fullest capacity possible through teletherapy service delivery.
4. By agreeing to engage in teletherapy, my therapist and I believe I would be served as well or better than other available forms of psychological services based upon my individual situation. If my therapist feels teletherapy is not beneficial or may be posing harm, I will be referred to a practitioner who can provide more appropriate services in my area.
5. To ensure public safety, I understand that it is the responsibility of this therapist as a mandated reporter to break confidentiality to advise local authorities for protection of either (a) a child, (b) an elderly person, (c) disabled/cognitively limited person, (d) self [suicidal ideation] or, (e) others I may pose a threat or report possible risks of these populations.
6. I understand that this therapist does not provide emergency services or crisis intervention for clients engaging in teletherapy. I understand that if I am crisis, I will call 911 or go to the nearest ER and I have discussed an emergency plan with this therapist.
7. I understand that if my level of mental health care need exceeds that of telehealth, I will consent to terminating that form of service and seek out in-person care.
8. I understand that this therapist is only licensed to provider mental health services in the state of California. Should I move out of this state, I am aware that I will need to find another provider in that new location. Additionally, I am aware that if I am out of the state for vacation or work purposes, I will have to withhold having teletherapy sessions with this therapist until I return to the state of California.
9. \_\_\_\_\_\_\_ (*Initial*). In addition, I agree to provide my address/location I will be using for each session.
10. \_\_\_\_\_\_\_ (*Initial*). I understand that I will receive an invoice at the onset of session to be paid via Square through an electronic method of payment. I consent to paying that fee at the time of the session.

My signature below indicates I have read, discussed, and understand this document, and I agree to abide by all points presented therein. My questions have been answered to my satisfaction and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

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Client Signature (Client’s Parent/Guardian if under 12) Date

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Client Signature Date

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Therapist Signature Date