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TELEHEALTH INFORMED CONSENT FORM

I _____ (client's name) hereby consent to engaging in telehealth with Jacqueline B. Smith, LMFT, psychotherapist, as part of my psychotherapy. I understand that "telehealth" (AKA: online counseling) includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in California or outside California.

I understand that I have the following rights with respect to telehealth:

- 1) I have a right to withhold or withdraw consent at any time without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- 2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting child, elder or dependent adult abuse; expressed threats of violence towards an ascertainable victim (self or others); and where I make my mental and emotional state an issue in a legal proceeding.
I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without any written consent.
- 3) I understand that there are risks and consequences from telehealth, including but not limited to the possibility, despite reasonable efforts on my part, that: The transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of therapeutic services (i.e., face-to-face, group, etc.) I will be referred to a psychotherapist that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

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- 4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- 5) I understand that I have a right to access my personal information and copies of case notes.
- 6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others; having uncontrolled psychotic symptoms; if I am in a life threatening or emergency situation; and/or if I am abusing drugs or alcohol, being unsafe. By signing this document, I acknowledge that I have been told that if I feel suicidal, I am to call 911, local count crisis agencies, or the National Suicide Hotline at 1-800-784-2433.

I have read and understand the information provided above. I have discussed these points with my psychotherapist, and all my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent and agree to its terms. I

Print Name

Signature of Patient

Date

Electronically Signed by Jacqueline B. Smith, LMFT
Signature of Psychotherapist

Date