JENNIFER S. BAILEY, MA, LMFT
LICENSED MARRIAGE AND FAMILY THERAPIST, MFC 52363
(818) 394-0890

10646 ZELZAH AVENUE
SUITE 207
GRANADA HILLS, CA 91344

# *Consent & Statement of Understanding Re: Telehealth*

**Client Information:**

Name _____ Date of Birth _____

Address_____

City_____State_____Zip_____

Email_____ Cell Phone #: _____

**Emergency Contact:**

**Name: _____Phone: _____**

California law has long recognized telehealth as a form of delivery of health care and behavioral health services, which many psychotherapists are practicing in the state of CA and throughout the U.S.

In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites.

Sometimes called telemedicine, teletherapy, distance therapy, e-therapy, internet therapy, or online therapy, telehealth involves using electronic media to provide interactive, real-time mental health services remotely, including consultation, assessment, diagnosis, treatment planning, counseling, psychotherapy, coaching, guidance, psychoeducation, and the transfer of medical information. Telehealth includes both video and audio communication, either over the phone or over the internet using videoconferencing software. This form of service is usually live videoconferencing through a personal computer with a webcam. Telehealth services don't include email or texting, however.

As a client, you are entitled to be educated about the risks and benefits with respect to telehealth. While this list is numerous, it is not exhaustive; however an effort has been made to enumerate several of importance. Please read and fill out the following to give

consent, and please feel free to discuss any questions or concerns you may have as a result of this list.

I, _____[name of client] hereby consent to engage in telehealth with **Jennifer S. Bailey, MA, LMFT** as part of my psychotherapy. I understand that "telemedicine or telehealth" 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 information, both orally and visually, to health care practitioners located in California.

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

(1) I understand the same laws and ethics that guide in-office, in-person, face-to-face mental health service also cover Telehealth. Therefore, the office policies and consent forms already in use in my therapist's office will apply to these telehealth services.

(2) I understand 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 is generally confidential. However, just like in regular sessions, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

(3) I understand that because there is a greater risk of being overheard by a third party on either end of a telehealth session, both parties will make every effort to conduct sessions in an enclosed private room and with no one else present or observing without the other's consent. That said, despite each of our best efforts, I understand that there is no guarantee of total confidentiality. While my therapist is choosing an encrypted, HIPAA-compliant platform upon which to conduct our telehealth sessions, no electronic transmission system can be considered completely safe from intrusion. Electronic media and the internet pose inherent risk for release of private information, including audio and images, and my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I understand that I alone am responsible for the security of my own laptop, tablet, or smartphone. Moreover, with my signature, I assent that both patient and psychotherapist agree to not record a telehealth session without prior written consent of both parties.

(4) I understand that my therapist may choose to conduct my telehealth sessions either via phone or a secure videoconferencing app. I understand that I may be required to download and/or log into such an app, or create an account to conduct our sessions.

(5) I understand that in the case of telehealth sessions, I will need to be billed via

Squarespace (AKA, “Square”) invoice. My fee will be the same as the fee I pay for my regular, in-person sessions. I understand that the regular office policies regarding payment that were agreed to by me by previously signing my therapist’s Office Policy/Informed Consent form apply to my telehealth sessions, too, and I am responsible for paying my invoice immediately, unless other arrangements need to be made.

(6) I understand that if I give less than 24 hour notice to cancel an appointment, I will be billed my full session fee for cancellation, the same as in the office setting.

(7) I understand that videoconferencing requires attention to video and audio quality, including sufficient light and minimal glare, camera angle so faces can be seen, and freedom from extraneous noise. I may need to use or purchase a headset or earbuds in order to hear best. "Doubletalk" may also occur, which is a phenomenon when people at both ends of the conference speak at the same time. Doubletalk may cause audio feedback, echo, or clipping because audio has a very slight delay.

(8) I also understand that there is a possibility that our technology may fail during a telehealth session, and that there may be an interruption; a need to continue by phone; or a need to reschedule. I authorize my therapist to contact my emergency contact (above) if she believes I may be in any danger during the therapy session.

(9) I understand that my therapist is only licensed in the state of California, and that if I must travel out of the state for business or vacation, I will not be able to engage in telehealth until my return.

(10) I understand that while telehealth can provide flexible continuity of care when an in-person service cannot be conducted, telehealth is not a universal substitute for in-person mental health service. Phone or conferencing sessions are to be conducted on an as-needed, interim basis, and is not a substitute for our regular, face-to-face sessions. Telehealth services may not provide the same level of comfort when talking about personal matters. Misunderstandings can occur, and this may have an impact on the therapeutic relationship: As a invested consumer of my own mental heath services, I will make every effort to bring my concerns about this to my therapist should this happen.

(11) I understand that telehealth is also not a substitute for emergency care, and if I find myself in a dangerous emergency situation, or other clinical emergency in which in-person assessment or intervention is necessary (e.g.: suicidality, psychosis, manic episode, etc.), I shall do the following:

**If you have an emergency, feel suicidal or homicidal please:**

1. **Call 911**
2. **Go to my nearest Hospital Emergency Room**
3. **Go to a Psychiatric Emergency Hospital: Northridge Hospital (818) 885-5484; Olive View Hospital (818) 364-4343**
4. **Call the Suicide Hotline (800) 273-8255**
5. **Call the Psychiatric Emergency Team: 800-854-7771**

(12) In addition, I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services), or if I move outside of my therapist's licensed state (CA), I will be referred to a psychotherapist who 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 psychotherapist, my condition may not be improve, and in some cases may even get worse.

(13) I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event, or condition on which this content expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date initiated. If there is no contact and no appointments scheduled for 60 days, my therapy file will be considered closed.

(14) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(15) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

**Signature of client**_____ **Date** _____