INFORMED CONSENT FOR TELETHERAPY

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Patients have a right to confidentiality with teletherapy under the same laws that protect the confidentiality for in-person psychotherapy. All Teletherapy sessions are conducted within the state of California and are governed by California state laws. Any Teletherapy sessions conducted must be within the physical boundaries of California. It is the responsibility of the patient to inform the therapist if they are not physically in California at the time of the session, and if not, then the Teletherapy services cannot be offered.

Due to recent advances in communication technology, the field of telehealth or tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and patient. Without this information, tele-therapy may be slower to progress or be less effective.

I, _____ (Patient's name), hereby consent to engage in telehealth with Dr. Nineveth Fauni, as part of my psychotherapy.

The information disclosed during the course of teletherapy is confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of abuse of a child, older adult, and dependent adult and any threats of violence the patient may make towards a reasonably identifiable person. If you will be in a level of mental or emotional condition to be a danger to yourself or others, Dr. Fauni has the right to break confidentiality to prevent the threatened danger.

It is your responsibility to make sure the environment you have chosen to engage in the teletherapy session is as private as possible. In this environment it is your responsibility to keep distractions to a minimum. In addition, it is your responsibility to protect confidential information within your own environment (prevent anyone from listening in to the session from somewhere else in the environment). As your therapist, I have the responsibility to do the same in my environment.

Teletherapy does not provide emergency services. If you are experiencing an emergency situation call **911**, call or visit the **Mary K. Shell Mental Health Center** (2151 College Ave., Bakersfield 93305; 1-800- 991-5272), or proceed to the nearest **hospital emergency room** for help. If you are having suicidal thoughts contact the *National Suicide Prevention Lifeline* at 1(800) 273-8255 or the *Crisis Text Line* (send a text to 741741). Both the National Suicide Hotline and Crisis Text Line are open 24 hrs. a day, every day of the year.

Teletherapy sessions are not to be recorded or captured as photos without your or Dr. Fauni's consent. If permission is given, photos or recorded teletherapy sessions cannot be disseminated to others via text, internet, email, or any other means.

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

1) I have the 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 is generally

confidential. However, 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. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

3) I understand that there are risks and consequences from Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of 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.
4) 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 psychotherapeutic services (e.g. face-to-face services), I will be referred to a psychotherapist who can provide such services in my area.
5) 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 improved, and in some cases may even get worse.
6) I understand that I may benefit from Telehealth, but that results cannot be guaranteed or assured.
7) I understand that if I am in need of emergency mental health services, I may contact or visit the *Mary K. Shell Mental Health Center* (2151 College Ave., Bakersfield 93305; 1-800- 991-5272), or proceed to the nearest *hospital emergency room* for help. If you are having suicidal thoughts contact the *National Suicide Prevention Lifeline* at 1(800) 273-8255 or the *Crisis Text Line* (send a text to 741741).
8) 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 Dr. Fauni, and all of my questions have been answered to my satisfaction. You have been provided with a copy of this document and have been given the opportunity to discuss your concerns and need for clarifications. Please remember that you may reopen the conversation at any time during our work together.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to abide by its terms during the course of our professional relationship.

Patient's Signature	Parent's Signature (If patient is under 18)
Patient's Printed Name	Parent's Printed Name
Date	Date
Psychologist's Signature	Date