

CONSENT FOR TELEHEALTH CONSULTATION

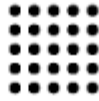
Telemedicine Treatment

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. I understand that my telemedicine sessions will be held via webcam on a HIPAA compliant website. Information about HIPAA can be found at www.dhcs.ca.gov/formsandpubs/laws/hipaa Telemedicine Sessions will be conducted via Zoom.

Risks and Expectations of Telemedicine Treatment

I understand that while the web-based therapy sessions conducted are HIPAA compliant, other digital communication may not be. If I contact FAMILY THERAPY SOLUTIONS, INC. through any other digital means, I do so with an understanding that confidentiality may be compromised.

- I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy.
- I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
- I understand that miscommunication between myself and my therapist may occur via Telehealth.
- I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
- I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location. I am aware that traveling outside of the state



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may impact my ability to receive services and agree to inform my therapist if I am outside of the state during a session.

- I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me out.

Payment & Cancellations

I understand that payment for telemedicine sessions are due prior to the clinical hour, and will be charged via credit card by FAMILY THERAPY SOLUTIONS, INC. The Credit Card Authorization form will need to have been completed and signed prior to commencing therapy. I am responsible for keeping my scheduled telemedicine appointment. Since the scheduling of a therapeutic session requires my therapist to reserve time, I understand that there is a 24 hour cancellation policy to our scheduled appointment. If I am not able to cancel at least 24 hour prior to my scheduled appointment, I agree to pay for that session at the regularly assigned fee.

Signature: _____

Printed Name: _____

Date: _____