Telemedicine Informed Consent Form

Name of Therapist: _____

License # & State: _____

I _____ hereby consent to engaging in telemedicine with (therapist name) _____ as part of my psychotherapy. I understand that "telemedicine" sessions will be conducted on Doxyme.com, or on an alternative HIPAA compliant platform (_____) that 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 I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand that in order to practice therapy utilizing telemedicine, I attest that I am located in the state of California and will be present in the state of California during all telehealth sessions.

_____

(Physical Address of Client at time of Telemedicine Session)

(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) I understand that the information disclosed by me during the course therapy is generally confidential. I understand that the laws that protect privacy and the confidentiality of patient medical information also apply to telemedicine. However, there are both mandatory and permissive exceptions to confidentiality, including, when the therapist suspects child or elder or elder dependent abuse, when a client is acutely suicidal, when the client is expressing harm to others or property of others, when one is acutely disoriented to person, place, or date and time or when expressed threats of violence towards an ascertainable victim or property. This also includes where I may make my mental and or emotional state an issue in a legal proceeding.

With respect to telemedicine:

(3) I understand that there are risks and consequences from telemedicine, including but not limited to the possibility, despite reasonable efforts on the part of my therapist, that:

- Transmission of my medical information could be disrupted. The electronic storage of my medical information could potentially be accessed by unauthorized persons.
- In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if I, or my therapist, believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I can be referred to a psychotherapist who can provide such services in my area.
- I understand if my session may be distorted by technical failures. I have the option to continue my session via telephone consultation.

(4) While I acknowledge that people do receive help and show improvement with therapy, I also understand that there is no guarantee of improvement with telemedicine or any form of therapy,

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.

☐ ***(please check box)*** I have confirmed verbally with my therapist that I am consenting to Telemedicine sessions at this time, irrespective of my completion and/or execution of this agreement.

_____ _____
Client name (please print) Date

_____ _____
Therapist name (please print) Date

Per California Law *(Therapist name)* _____ is licensed to practice only in State of Licensure. Client is also required to be in California at time of session.)