



Telemedicine Informed Consent 2021

I, _____ (name of client/parent/guardian), on behalf of my child (if applicable), _____ hereby consent to engaging in telemedicine with _____ (CFCG Therapist) as part of therapy.

I understand “telemedicine” includes health care delivery, diagnosis, consultation, treatment, transfer of medical/psychological data, and education using interactive audio, video or data communications. I understand that telemedicine involves the communication of my family’s mental health information, orally and visually, to health care providers within California. Any services outside the state are limited to “coaching” only, and no psychotherapy services, including assessment or intake appointments are provided outside the state lines.

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

- 1) I have been given the opportunity to engage in telemedicine at my request. 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 could be entitled.
 - 2) Laws that protect confidentiality of my health care also apply to telemedicine. As such, I understand the information we exchange in the course of therapy is generally confidential. However, all mandated reporting laws about dangerousness to self or others do apply including child abuse, elder/dependent adult abuse, expressed threats of violence towards an ascertainable victim; and where I make the mental/emotional state of any family members an issue in legal proceedings. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.
 - 3) I understand there are risks and consequences from telemedicine, including but not limited to the possibility that despite reasonable efforts on the part of CFCG staff that the transmission of protected health information could be disrupted or distorted by technical problems; the transmission of mental health information could be interrupted by unauthorized persons; and/or the electronic storage of my mental health information could be accessed by unauthorized persons.
- I understand that if my insurance company determines that all requirements/conditions have not been met such as the use of HIPAA compliant telemedicine platforms, they may deny a claim for telemedicine services.
- In addition, I understand that telemedicine-based services may not be as complete as face-to-face services. I understand that if my therapist believes I would be better served by another form of services, my therapist will address this with me and help me to determine my options, including referral to another provider.
- 4) 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, the condition of myself or my family member may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
 - 5) I understand I have the right to access mental health records, information, and to obtain copies, in accordance with California law. (Your therapist would address pros and cons of obtaining records vs. a summary of care if you were to request records.)

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

Name (Client/Parent/Guardian 1) and Signature/Date

Name (Parent/Guardian 2) and Signature/Date

Signature of Therapist: _____