



Telehealth Informed Consent Form

You have been invited to participate in “telehealth” therapy whereby through electronic means you will connect with your psychotherapist. Marriage and Family Therapists must follow legal and ethical guidelines in order to treat you through telehealth. Additionally, at times other restrictions imposed upon your psychotherapist (e.g. limits from your insurance carrier) may prevent them from this mode of therapy.

The Law: CA Code of Regulation Title 16 Section 1815.5: Standards of Practice for Telehealth

(a) All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a client who is physically located in this State must have a valid and current license or registration issued by the Board.

(b) All psychotherapy services offered by board licensees and registrants via telehealth fall within the jurisdiction of the board just as traditional face-to-face services do. Therefore, all psychotherapy services offered via telehealth are subject to the board’s statutes and regulations.

(c) Upon initiation of telehealth services, a licensee or registrant shall do the following:

- (1) Obtain informed consent from the client consistent with Section 2290.5 of the Code.
- (2) Inform the client of the potential risks and limitations of receiving treatment via telehealth.
- (3) Provide the client with his/her license/registration number & the type of license/registration.
- (4) Document reasonable efforts made to ascertain the contact information of relevant resources, including emergency services, in the client’s geographic area.

(d) Each time a licensee or registrant provides services via telehealth, he/she shall do the following:

- (1) Verbally obtain from the client and document the client’s full name and address of present location, at the beginning of each telehealth session.
- (2) Assess whether the client is appropriate for telehealth, including, but not limited to, consideration of the client’s psychosocial situation.
- (3) Utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium.

(e) A licensee or registrant of this state may provide telehealth services to clients located in another jurisdiction only if the California licensee or registrant meets the requirements to lawfully provide services in that jurisdiction, and delivery of services via telehealth is allowed by that jurisdiction.

(f) Failure to comply with these provisions shall be considered unprofessional conduct.



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I, _____ [client name] hereby consent to engaging in telehealth with _____ [] Licensed, or [] Associate, or [] Trainee Marriage and Family Therapist at HOPE; Healthy Outcomes for Personal Enrichment Counseling Center, as part of my psychotherapy. I understand that 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 or outside of California (if licensed to do so).

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 or 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 telehealth 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 (Licensee/Associate/Trainee), 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.

In addition, 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. 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 improve, and in some cases may even get worse.

- (1) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- (2) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.
- (3) I have signed an agreement for services that explains traditional face-to-face services.

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/parent/guardian/conservator

Date

Signature of additional client/parent/guardian/conservator

Date

If signed by other than client indicate relationship

Signature and Type of Therapist (check below)

Date

[] Licensed Marriage and Family Therapist # _____

[] Associate Marriage and Family Therapist # _____

[] Marriage and Family Therapist Trainee