Healing Hearts
Family Counseling Inc.
Sheila Lynn Hansen, MA, LMFT 115782, RPT T4545
1601 Dove Street, Suite #193, Newport Beach, CA 92660 • (949) 424-4083

Teletherapy Informed Consent Form

I, _____ (parent/guardian) of minor child _____ (client) hereby consent to engaging in telemedicine with Sheila Lynn Hansen, MA, Licensed Marriage & Family Therapist #115782 and Registered Play Therapist #T4545 operating as Healing Hearts Family Counseling, Inc. (therapist/healthcare provider) as part of my psychotherapy and understand that my healthcare provider wishes me to engage in a telemedicine/telehealth consultation/session. I understand that "telemedicine/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 telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

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

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 telemedicine. 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 telemedicine, 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.

   My therapist/healthcare provider has explained to me how the video conferencing technology that will be used to affect such a consultation/session will not be the same as a direct client to therapist/healthcare provider visit due to the fact that I will not be in the same room as my therapist/healthcare provider. 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 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 be improve, and in some cases may even get worse.
4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.
6) I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
7) I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult /visit if it is felt that the videoconferencing connections are not adequate for the situation.

Healing Hearts
Family Counseling Inc.

I have read and understand the information provided above. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____
Name of Client (Print)

_____ Date: _____
Parent/Legal Guardian Signature or Client (12 years or older)

_____ Date: _____
Parent/Legal Guardian Signature or Client (12 years or older)

(Use additional date and signature lines as necessary. If someone is signing in a representative capacity, such as a court-appointed guardian or conservator, such capacity should be stated, and the person being represented should be specified.)