

Cathy Hanville, LCSW
405 Kains Avenue, Ste 102, Albany, CA 94706
(415) 643-3890

Telehealth Consent

I _____ (client's name) hereby consent to engage in telehealth with Cathy Hanville, LCSW (LCS 19782) 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.

Client Rights in respect to Telehealth

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.
- 2) You have the same rights to confidentiality that I outlined in my Informed Consent. The extent of confidentiality and the exceptions to confidentiality still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Technology

We will meet on a telemedicine platform that is HIPAA compliant. This VC platform is encrypted to the federal standard, HIPAA compliant, and has signed a HIPAA Business Associate Agreement with me. This BAA means they attest to HIPAA compliance and assume responsibility for keeping our VC interaction secure and confidential. You do need to have access to a strong consistent internet connection for this technology. If something interferes with our connection, we can talk by phone as a back-up or reschedule the session.

I follow the laws and professional regulations of the State of California (USA) and the psychotherapy treatment will be considered to take place in the state of California (USA). I do not conduct online therapy with clients whose permanent domicile is located outside my license jurisdiction.

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Emergency Procedures Specific to Tele Mental Health Services

There are additional procedures that we need to have in place specific to Tele Mental Health services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Tele Mental Health services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: _____

Phone: _____

You agree that each time we meet online you will tell me the address you are located at, if you are in a place where you can speak confidentially, and if you expect you might be interrupted.

You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Tele Mental Health session). Please list this hospital and contact number here:

Hospital: _____

Phone: _____

If the session is interrupted for any reason, such as technological failure, and you are having an emergency, do not call me back; instead, call 911, or

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the suicide hotline 1-800-309-2131, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on this phone number 415-643-3890.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Risks of Telehealth

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, 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.

Tele-therapy may or may not be as effective as in-person therapy while you may receive benefits from telehealth, results cannot be guaranteed or assured.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates that you have read and understand the information provided above.

Signature

Date