

Laurie Schoenberg MS, MA
Licensed Marriage Family Therapist #43064
(951) 514-5744

Telehealth Consent Form

I, _____ [Name of Client], hereby consent to engaging in telemedicine with Laurie Schoenberg MFT, as part of my 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.

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

- (1) I have the right to withhold or withdraw consent at anytime without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefit 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 and issue in a legal proceeding.
- (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 therapist, 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 therapist believes would be better served by another form of therapy services (e.g. face-to-face services) I will be referred to a therapist 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 therapist, my condition may not improve, and in some cases may even get worse.
- (4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- (5) I understand I have a right to access my medical information and copies of medical records in accordance with California law.
- (6) I understand that miscommunication between myself and my therapist may occur via Telehealth.
- (7) I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
- (8) I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

- (9) I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
- (10) I have discussed the fees charged for Telehealth with my therapist and agree to them (or for insurance clients; I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the client's responsibility (e.g. co-payment), and I have been provided with this information in the Informed Consent Form.
- (11) I understand my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist will not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.
- (12) **I understand my therapist will not be able to conduct a Telehealth session in a moving vehicle (both as a driver and/or passenger). Therapist will end session until client has stopped the vehicle and is parked in a safe location to continue the session.**

I have read and understand the information provided above. I have discussed it with my therapist and all my questions have been answered to my satisfaction.

For conjoint of family therapy, client may sign individual forms or sign the same form.

Signature of client/Representative If signed by other than client-indicate who?

Print Name

Date: ____/____/____ Therapist: _____