Healing from the Past,
Help for the Present,
Hope for the Future

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Telemedicine Informed Consent

I _____ (patient's name) hereby consent to engaging in telemedicine with Darcy Greene, Licensed Marriage and Family Therapist, as part of my psychotherapy. I understand that "telemedicine" 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.

Due to recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Since it is relatively new, there is not a lot of research indicating it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. Without this information, tele-therapy may be slower to progress or less effective. With the telephone, the client's tone of voice, pauses and choice of words become especially important and therefore an important focus of the sessions. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

In the event we have not met in person, I may request that you be interviewed before proceeding with therapy. With tele-therapy, there is the question of where is the therapy occurring – at the therapist's office or the location of the client? The law has not yet clarified this issue, therefore it is my policy to inform clients they are receiving services from my office (as if they were physically traveling to Lake Forest) and therefore are bound by the laws of the State of California. Because I am licensed by the state of California you must also be in California at the time of our sessions. These laws are primarily related to confidentiality as outlined in this form and my Informed Consent form.

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.

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 I must be in the state of California to receive treatment via telemedicine from Darcy.

I have read and understand the information provided above as well as the information in Darcy's standard Informed Consent. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

I understand I must physically be located in California during my sessions

_____

I declare I am/will be located in California during my sessions

Signature of patient/parent/guardian/conservator. If signed by other than patient indicate relationship:

Client Signature_____

Printed Name_____

Date _____ Time_____

Address _____

Phone(s) _____ Fax _____

E mail _____

Client's Emergency Contact Information:

_____

Couple, Parent and/or Guarantor Signature (if applicable)

_____

Date _____ Time_____

Address _____

Phone(s) _____ Fax_____ Email_____

Darcy Greene, Therapist, Signature _____

Date and Time_____

Payment Information:

Credit Card Name:_____

Card #: _____

Expiration Date:_____ Security Code: _____

Billing Address Zip Code: _____