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

Darcy R. Greene MA, LMFT (MFC #53395)
Crossroads Counseling
Licensed Marriage Family Therapist

CONSENT FOR TELEHEALTH CONSULTATION

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 "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using an interactive audio video platform. My health care provider has explained to me how the video conferencing technology will not be the same as a direct client/health care provider visit due to the fact I will not be in the same room as my provider.

I understand a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I also understand I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand my health care provider or I can discontinue the telehealth consult/visit if it is felt the videoconferencing connections are not adequate for the situation.

In the event we have not met in person, I may request you to 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? It is my policy to inform clients they are receiving services from my office (as if they were physically traveling to Laguna Hills) 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.

23272 Mill Creek Drive #100
Laguna Hills Ca. 92653
(949) 415-6383
Fax (949) 203-0418
Info@DarcyGreene.org

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 which protect the confidentiality of my medical information also apply to telemedicine. As such, I understand 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 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 there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist: 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 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 there are potential risks and benefits associated with any form of psychotherapy and 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 I may benefit from telemedicine but 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 I must be in the state of California to receive treatment via telemedicine from Darcy.

(7) I understand Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911. Though my provider and I may be in direct, virtual contact through the Telehealth Service, I understand the Telehealth Service does not provide any emergency or urgent medical services.

23272 Mill Creek Drive #100
Laguna Hills Ca. 92653
(949) 415-6383
Fax (949) 203-0418
Info@DarcyGreene.org

I have read and understand the information provided above as well as the information in Darcy's standard Informed Consent. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

Signature

_____

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

_____

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

_____ _____

Name of Emergency Contact Person Phone Number

23272 Mill Creek Drive #100
Laguna Hills Ca. 92653
(949) 415-6383
Fax (949) 203-0418
Info@DarcyGreene.org