Kathy Wei, LCSW76613, RYT® 200
242 West Main Street, Suite 200F, Tustin, CA 92780
Phone: (949) 328-6696

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

Please read carefully, fill in the blank on page one and page two, initial at the bottom of each page, sign and date on the last page.

I _____(patient's name) hereby consent to engage in telehealth with Kathy Wei, LCSW 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 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 any time without affecting my right to future care or treatment nor 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 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 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 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.

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 psychotherapist believes I would be better

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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 telehealth, but that results cannot be guaranteed or assured.

5) I understand that if I am in need of emergency mental health services, I may contact my local Emergency Room at _____ or call 911.

6) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

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

I hereby authorize Kathy Wei, LCSW to use Telehealth in the course of my diagnosis and treatment.

Print Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Signature: _____

(Client/Parent/Conservator/Guardian)

Provider: Kathy Wei, LCSW_____ Date: _____

Provider's Signature: _____