Lisa K. Phillips Ph. D.

LICENSED CLINICAL PSYCHOLOGIST

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INFORMED CONSENT FOR TELETHERAPY

This document represents our agreement to use teletherapy as part of your established mental health treatment. It serves as an adjunct to our signed "Informed Consent for Treatment," whose policies and procedures remain in effect (i.e., limits to confidentiality, maintenance and access to records, fees, billing and payment, arranging appointments, and cancellation policy).

Teletherapy includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of personal health information using interactive audio, video, or data communications such as the telephone, cellular phones, the internet, and various programs such as DOXY.ME.

(1) I am aware that Dr. Phillips is a psychologist licensed by the California Board of Psychology and is licensed to provide services in the state of California. With this knowledge, I am voluntarily choosing her as my preferred therapist. I have the right to withhold or withdraw consent at any time.

(2) I understand that there are potential risks and benefits associated with any form of psychotherapy, including teletherapy, and treatment results cannot be guaranteed. Teletherapy can oftentimes be as good as or better than other available options. Dr. Phillips offers teletherapy to established clients based on their individual circumstances to provide quality treatment, assure continuity of care, and respect each client's preferences for preferred service modality. Please briefly note in your own words your reason for choosing teletherapy:

_____

_____

(3) I understand that Dr. Phillips does not provide emergency services or crisis intervention for clients engaging in teletherapy. I understand that if I am crisis I will call 911 or go to the nearest ER and I have discussed an emergency plan with Dr. Phillips.
_____ (*Initial*). In addition, I agree to provide my address/location I will be using for each session.

(4) The laws that protect my confidentiality in face-to-face therapy (as detailed in my copy of Informed Consent for Treatment) also apply to teletherapy. As such, I understand that the information disclosed by me during the course of teletherapy is confidential with the same mandatory and permissible exceptions to confidentiality.

(5) I am aware that use of technology introduces certain risks to my confidentiality. Risks include, but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be intercepted by unauthorized persons; and/or any electronic storage of my personal information could be accessed by unauthorized persons. I also understand that the programs listed above have their own policies that might interfere with confidentiality, and I am fully aware of the risks associated with working with these programs.

(6) I understand that teletherapy services and care may not be as complete as face-to-face services. By agreeing to engage in teletherapy, my therapist and I believe I would be served as well or better than other available forms of psychological services based upon my individual situation. If my therapist feels teletherapy is not beneficial or may be posing harm, I will be referred to a practitioner who can provide more appropriate services in my area.

My signature below indicates I have read, discussed, and understand this document, and I agree to abide by all points presented therein. My questions have been answered to my satisfaction, and I am encouraged to ask further questions as needed.

_____ _____

Signature of Client Date

_____ _____

Signature of Dr. Lisa Phillips, Ph.D. - CA License # PSY 25324 Date