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## TELEHEALTH THERAPY CONSENT FORM

I, \_\_\_\_\_ have requested, and by my signature below, hereby consent to the provision of  
(Patient name)  
psychological services by Ginny Liwanpo, Psy.D. via Telehealth Therapy. This Consent for Telehealth Therapy incorporates and is in addition to that Consent for Treatment signed by me at the beginning of treatment.

**WHAT IS TELEHEALTH THERAPY?** Telehealth Therapy refers to the delivery of psychological services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at an "originating site" and the health care provider is at a "distant site". In California, telehealth includes both synchronous ("face to face") interactions and asynchronous store and forward transfers.

- Information and Communication Technology ("ICT") refers to the storage, retrieval, manipulation transmission or receipt of information electronically in a digital form using computer-based technology (your personal computer) over a network or the internet. An example of ICT is my having a discussion over Skype in which audio and visual data is communicated from my personal computer via a telephone or fiber optic cable to another computer at a distant site.
- "Distant site" refers to the site where my psychologist is located while providing these services via a telecommunications system (e.g. this Office).
- "Originating site" refers to the site where I will be located at the time the psychological services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Asynchronous store and forward" (ASAF) means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. ASAF differs from real-time "live" or "face to face" communication in that the patient is not present when the health care provider accesses the information.
- "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

**WHAT ARE SOME OF THE BENEFITS OF TELEHEALTH THERAPY?** Telehealth facilitates patient convenience and self-management by increasing flexibility and thus the ability of the patient to access psychological services such as when a patient may be homebound, restricted in the ability to travel, or located too far from the office of his or her psychotherapist so that an in-office or face to face visit would be impractical or impossible. Telehealth Therapy may also make quick "check-in" sessions possible that would otherwise be impractical and add additional expense. There may at times be added benefits to the patient resulting from being able to speak to a psychotherapist from the privacy and security of the patient's home.

**WHAT ARE SOME OF THE RISKS OF TELEHEALTH THERAPY?** As with any form of technology, Telehealth Therapy is dependent on the effective operation of the internet, an effective communication signal, and on the electronic devices involved. Networks are subject to interruptions, delays, system overloads, and other technical difficulties. Because the quality of Telehealth Therapy is dependent on working technology, its effectiveness may be severely hampered when technology fails.

Privacy, security and confidentiality present additional risks. Even when healthcare providers take necessary precautions, they cannot guarantee the privacy, confidentiality or security of my protected health information from hackers and other unauthorized access. I acknowledge that it is my responsibility to participate in safeguarding my privacy at the originating site by controlling my environment, including guarding against interruptions by others during sessions and being overheard during sessions, and by protecting the security of my communications by using appropriate encryption, password protection, automatic screen lock technology and limiting access by others.

I also recognize that as a result of my desire to participate in Telehealth Therapy, my psychotherapist may be limited in the extent to which he or she may be able to assess me during telehealth sessions, and in the manner in which he or she might intervene or react to me under certain circumstances. If at any time our use of technology raises any concerns for me I will make them known to my psychotherapist, and in particular if I ever feel unsafe, I will let my psychotherapist know immediately. If he or she anytime requests that I present for a face to face evaluation, I agree to do so.

**ACCESS TO OFFICE VISITS.** My decision to participate in Telehealth Therapy does not prohibit my seeing my psychotherapist at any time pursuant to a regularly scheduled appointment. I understand that I may seek an appointment to meet in my psychotherapist's office at any time notwithstanding my ongoing participation in Telehealth Therapy. Moreover, my decision to participate in Telehealth Therapy may be revoked 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 (or my legal representative) would otherwise be entitled.

**FEES.** I understand that I am financially responsible for all fees and expenses related to my treatment and for all expenses associated with implementing the technology for Telehealth Therapy used at my home or any other originating site (such as the purchase of my own computer, access and network charges). Using Telehealth Therapy will not result in any additional fees other than the professional fees I have agreed to pay pursuant to the current fee schedule with this Office. I understand that to the extent I may have coverage for psychological services through an insurer, health plan or other third-party payer, such coverage may vary to the extent it covers Telehealth Therapy. It is my responsibility to verify the specifics of my coverage, and my responsibility to pay in full for all services including any Telehealth Therapy services that are not covered by my insurer.

**PATIENT RIGHTS TO CONFIDENTIALITY AND ACCESS TO INFORMATION.** My decision to participate in Telehealth Therapy does not limit any of my rights to confidentiality or to access my records under State or Federal law. No protected health information may be disclosed, including dissemination of any patient identifiable images or information from the Telehealth Therapy sessions whether to researchers or other entities without my written consent.

## CONSENT FOR TELEHEALTH THERAPY:

*I have read and fully understand this entire document and have had the opportunity to have any questions I have explained to me verbally to my complete satisfaction prior to the commencement of Telehealth Therapy. By signing below, I voluntarily agree to participate in Telehealth Therapy and agree to comply with what has been outlined above.*

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Patient Name	Signature	Date
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Name of Legal Guardian/Parent if under 18	Signature	Date
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Provider Name	Signature	Date
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