

Telemedicine Informed Consent

I _____ hereby consent to engaging in telemedicine (e.g. Internet or telephone therapy) with Alice E. Shannon, MFT as part of my psychotherapy treatment. I understand that "telemedicine" includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. **However unless we have met in person and established a client-therapist relationship, phone and any internet communication will be considered consultation, coaching and educational in nature and not psychotherapy.**

I understand that I have the following rights with respect to telemedicine.

1. I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that information disclosed by me during the course of 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; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would better served by another form of psychotherapeutic service (e.g. face-to-face service) I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite efforts and the efforts of my psychotherapist, my condition may not improve, and in some case even get worse.

4. I understand that I may benefit from telemedicine, but the results cannot be guaranteed or assured. The benefits may include, but are not limited to: some greater ability to express thoughts and emotions, transportation and travel difficulties are avoided, time constraints are minimized, and there may be greater opportunity to prepare, in advance for therapy sessions.
5. I understand I have a right to access my medical information and copies of my medical records in accordance with California law.

The fee for my services is 100.00 per hour, or \$25.00 per quarter hour. Written feedback has a minimum fee of \$75.00 per document. Client is responsible for payment by check in advance of the appointment. Client will call my number (either 707 822-1716 or 707 839-0444 to be determined in advance) at the scheduled appointment time. There is a \$25.00 charge for a missed appointment without 24 hours notice. My phone work is temperament based, including issues relevant to temperament. Phone appointments should be considered supplemental advice and consultation which does not take the place of face to face meetings or observations particularly when the concerns pertain to a child. Although I am usually able to return calls in a timely basis and you may leave a message at any hour I am not available on a 24 hour basis.

I have read and understood the above information discussing any questions I might have with my psychotherapist.

Signature of client _____ Date _____

Signature of psychotherapist _____