Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with Diane Byster, LMFT, NCC, RYT as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health:

1) I have the right to withdraw consent for telemental health at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) There are risks, benefits, and consequences associated with telemental health, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (e.g., mandatory reporting of child, elder, or vulnerable-adult abuse; danger to self or others; or I raise mental/emotional health as an issue in a legal proceeding).

5) If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental-health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) During a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we should end and restart the session. If we are unable to reconnect within ten minutes, please call Diane Byster at 650-482-9577 to discuss; we may need to reschedule the session for another time.

7) My therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

Your therapist needs to know your location in case of an emergency. You agree to inform her of the address where you are at the beginning of each session. She also needs a contact person she may contact on your behalf in a life-threatening emergency only. This person will be contacted only to go to your location or take you to a hospital in the event of an emergency.

In case of an emergency, my location is:

and my emergency contact's name, address, phone:

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date