Mónica
S. REYNOSO MS, LMFT, LPCC
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor

Consent & Statement of Understanding Audio/Visual Sessions

Client Information:

Name: _____ Date of Birth:_____

Home Address:_____

City:_____State: _____Zip:_____

Email: _____ Phone: _____ Cell / Home

I hereby authorize *Monica S. Reynoso, LMFT, LPCC* to use Doxy.me as means of psychotherapy. Doxy.me is a HIPAA compliant platform for telehealth. I further attest that since I have chosen this form of communication. I have been advised that it may not be covered by my insurance company and that I may be responsible for any fees incurred during psychotherapy which incorporates telehealth.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire on year after the date it was initiated.

_____

Client Signature (age 14 and over) **Date**

_____

Parent / Guardian of Minor **Date**

_____

Witness **Date**

Telehealth Informed Consent Form

I hereby consent to engaging in TeleHealth psychotherapy with my existing therapist, ***Monica S. Reynoso, LMFT, LPCC***. I understand that TeleHealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communication. I understand that TeleHealth psychotherapy also involves the communication of my medical/mental information, both orally and visually, to ***Monica S. Reynoso, LMFT, LPCC*** via the TeleHealth service, Doxy.me (a HIPAA compliant video platform service).

I understand that I have the following rights with respect to TeleHealth psychotherapy.

(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 applies to TeleHealth psychotherapy. 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, independent 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 dissemination of any personally identifiable images or information from the TeleHealth psychotherapy interaction to researchers or other entities shall not occur without my written consent.
(3) I understand that there are risks and consequences from TeleHealth psychotherapy, including, but not limited to, the possibility, despite reasonable effort on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by an unauthorized persons (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that TeleHealth psychotherapy based services and care may not be as complete as face-to-face services. I also 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 improved, and in some cases may even get worse.
(4) I understand that I may benefit from TeleHealth psychotherapy, but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.
(6) I understand that, per the ethical guidelines of the state of California, TeleHealth psychotherapy services can ONLY be provided to those residing in the state of California at the time of service.

(7) I also understand that TeleHealth psychotherapy is not always a covered service by my insurance plan, and it is my responsibility to check with my individual plan to determine if TeleHealth is authorized. The client will ultimately be responsible for all fees related to TeleHealth that insurance does not cover.
(8) Telehealth will be billed at the same rate of individual therapy services.
(9) Telehealth is a temporary service that is being offered to all clients due to extreme circumstances as a precautionary measure. Once these circumstances abate, psychotherapy sessions will return to in-person services as previously scheduled. Please contact ***Monica S. Reynoso, LMFT, LPCC*** directly if you have any questions.

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.

_____ _____

Client Name (please print) Name of Authorized Representative (please print)

_____ _____

Signature of Client Signature of Authorized Representative

Date: ____ / ____/ ____