Candy Katoa, Psy.D.
Clinical Psychologist
CA PSY 24477

Teletherapy Informed Consent

I _____ hereby consent to engage in teletherapy (e.g., internet or telephone based therapy) with Dr. Candy Katoa. I understand that teletherapy includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

I understand that I have the following rights with respect to teletherapy:

1. 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 teletherapy. 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, and dependent adult abuse; suicidality or imminent danger to myself; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from teletherapy. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my provider, 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 teletherapy may not yield the same results nor be as complete as face-to-face service. I also understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be given referrals to other providers 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 my efforts and the efforts of my provider, my condition may not improve and in some cases may even get worse.

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4. I understand that I may benefit from teletherapy, but results cannot be guaranteed or assured. The benefits of teletherapy may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

5. I accept that teletherapy does not provide emergency services. During our first session or prior, Dr. Candy Katoa and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

6. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

7. I understand that I must be physically located within California during each of my teletherapy sessions.

8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and California law.

I have read, understand and agree to the information provided above.

Signature:_____ Date:_____

Print Name: _____

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