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

Teletherapy Informed Consent

I _____ hereby consent for my child _____ 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 child's right to future care or treatment.

2. The laws that protect the confidentiality of my child's medical information also apply to teletherapy. As such, I understand that the information disclosed by my child 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; suicidality or imminent danger to self; expressed threats of violence towards an ascertainable victim; and where my child's mental or emotional state is 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 child's medical information could be disrupted or distorted by technical failures; the transmission of my child's medical information could be interrupted by unauthorized persons; the electronic storage of my child's 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 child's provider believes my child 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 child's efforts and the efforts of the provider, my child's condition may not improve and in some cases may even get worse.

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4. I understand that my child 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 my child's first session or prior, Dr. Candy Katoa and I will discuss an emergency response plan. If my child is experiencing an emergency situation, I understand that I can call 911 or take my child to the nearest hospital emergency room for help. If my child is having suicidal thoughts or making plans to harm himself or herself, 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 child's 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 child's teletherapy session.

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

8. I understand that I have a right to access my child's 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.

Parent Signature:_____ Date:_____

Print Parent's Name: _____

Print Child's Name: _____

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