Cindy May, Ph.D.
Adolescent and Adult Clinical Psychologist
1101 Dove Street, Suite 155
Newport Beach, CA 92660

TELETHERAPY CONSENT FORM

I hereby authorize Cindy May, Ph.D. to use teletherapy in the course of my diagnosis and treatment. I understand that teletherapy involves the communication of my healthcare information, both orally and/or visually, to therapists located in other parts of the state and/or country. I understand I have all the following rights with respect to teletherapy:

Patient Choice of Care

I have the right to withhold or withdraw my consent to teletherapy at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

Access to Information

I have the right to inspect all healthcare information transmitted during a teletherapy consultation; and may receive copies of this information for a reasonable fee.

Confidentiality

I understand that the laws which protect the confidentiality of medical information apply to teletherapy; that I will not be recorded; and that no information from the teletherapy interaction which identifies me will be disclosed to researchers or other entities without my consent.

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Potential Risks.

I understand that there are risks from teletherapy, including the possibility, despite reasonable and appropriate efforts, that: the transmission of medical information could be disrupted or distorted by technical failures in transmission; the information transmitted may not be sufficient (e.g. poor video or audio quality) to allow for appropriate medical decision making; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage or medical information generated by this teletherapy consultation in one or more databases could be accessed by unauthorized persons. In addition, I understand that teletherapy examinations or care may not be as complete as face-to-face examinations or care and that teletherapy does not negate or minimize the risks that may be inherent in a mental disorder or condition. I understand that in certain rare circumstances, Dr. May may request a face-to-face examination either with herself or will direct me to another healthcare profession and I will make every effort to do so.

Finally, I understand that it is impossible to list every possible risk; that my condition may improve, and in rare cases, may get worse. Consequences. I understand that by consenting to teletherapy my therapist will communicate medical information concerning me to other health care practitioners located in other parts of the state or outside the state, such as my Primary Care Physician or Psychiatrist.

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Benefits

I understand that I can expect benefits from teletherapy, but that no results can be guaranteed or assured. Teletherapy provides me with access to mental health care and/or continuity of care that otherwise would not have been available in my community. I have read and understand the information provided above, I have discussed it with my therapist and all my questions have been answered to my satisfaction.

Date: _____

_____

Signature of patient / parent / conservator / guardian (circle one)