Consent and Statement of Understanding Regarding Teletherapy Sessions

Katie Fenton-Strauss, LCSW #LCS22537

mytherapistkatie.com

Client Information:

Name _____ Date of Birth _____

Street Address_____

City_____State_____Zip_____

Email_____ Phone _____

Emergency contact name: **Emergency contact number:**

_____ _____

I hereby authorize Katie Fenton-Strauss, LCSW to use HIPPA compliant and secure telemedicine technology for our therapy sessions.

I understand that there is a possibility that our technology may fail during a teletherapy session, and that there may be an interruption or need to reschedule. I authorize therapist to use my address info and emergency contact as part of a safety plan, should an emergency arise.

I understand that during the therapy process, my therapist may decide that teletherapy is not the most appropriate type of therapy for my needs, and may help connect me to other mental health services.

I understand that my therapist is only licensed to practice in the state of California. I understand that if I move or travel out of the state, I will need to obtain other mental health services.

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 content expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date initiated.

_____

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

_____

Parent/Guardian of Minor **Date**