

Consent and Statement of Understanding Regarding Teletherapy Sessions

Katie Fenton-Strauss, LCSW

Client Information:

Name _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

Emergency Contact name:

Emergency Contact number:

I hereby authorize Katie Fenton-Strauss, LCSW to use 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; a need to continue by phone; or a need to reschedule. I authorize my therapist to contact my emergency contact (above) if she believes I may be in any danger during the therapy session.

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

I understand that if I use insurance to pay for sessions, there is another party that will be given access to billing info. **This party will not have access to any confidential clinical information.**

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