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 give less than 24 hour notice to cancel an appointment, I will be billed a $75 cancellation fee.

I understand that if I choose to use insurance to pay for sessions, I am permitting another party to have access to requested information. I have read and understand the HIPPA regulations (Notice of Privacy Practices) form found on www.mytherapistkatie.com

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. If there is no contact and no appointments scheduled for 60 days, my therapy file will be considered closed.

_____

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

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Parent/Guardian of Minor **Date**