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Informed Consent for Telehealth Services

I understand that Telehealth is an electronic information and communication technology used by a Mental Health provider to deliver services to an individual when he/she is located at a different site than the provider. And I hereby consent to Christina Collins, LMFT, providing counseling services to me via Telehealth. Applications may include: FaceTime, videoconferencing, text messages, email, or any other electronic means. Accordingly, my private health information may be transmitted from my Therapist's mobile device to my own or from my device to that of my Therapist. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth. As always, your insurance carrier will have access to your records if records are submitted for reimbursement. I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Christina Collins, LMFT at 8 Crow Canyon Court, Suite 105, San Ramon, CA 94583, telephone 925-878-1500.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433. I have read and understand the information provided above. I have discussed these points with my psychotherapist, and all my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent and agree to its terms.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my 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; expressed threats of violence towards an ascertainable victim; and where I make my mental and emotional state an issue in a legal proceeding.

Signature of patient/parent/guardian/conservator

Date

If signed by other than patient, indicate relationship