

INFORMED CONSENT: TELEHEALTH

I hereby consent to engage in teletherapy with EVELINE SMILACK, MFA, LMFT #91090. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights and responsibilities with respect to teletherapy:

- I must be a resident of California. (Legal requirement for psychotherapist practicing under a California license.)
- I can withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to teletherapy. Information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with EVELINE SMILACK, MFA, LMFT #91090.
- There are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychotherapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems.
- Teletherapy based services and care may not be as complete as face-to-face services.
- If my psychotherapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services, I will be referred to a professional who can provide such services in my area.
- I may benefit from teletherapy, but results cannot be guaranteed or assured.
- There are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

Eveline Smilack, MFA, LMFT
Licensed Marriage & Family Therapist #91090
Practice of Psychotherapy

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- Teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1 (800) 273-TALK (8255) for free 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my psychotherapist will recommend more appropriate services.
- There is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.
- Dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding telehealth: described above.

Name (Print): _____ **Date:** _____

Signature: _____

As Witnessed By Therapist:

Name (Print): _____ **Date:** _____

Signature: _____