Christina Ingenito, LCSW
LCS11949

115 Liberty Street, Suite 9
Petaluma, CA 94952
christinaingenito@gmail.com

PHONE: 707.773.7755
FAX: 413.677.1222
www.christinaingenito.com

TELE-HEALTH PSYCHOTHERAPY CONSENT FORM

Definition of Services:

I,_____, hereby consent to engage in tele-health psychotherapy with **Christina Ingenito, LCSW**. Tele-health psychotherapy 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 tele-health psychotherapy involves the communication of my medical/mental health information, both orally and/or visually. Tele-health psychotherapy has the same purpose or intention as psychotherapy sessions that are conducted in person. However, due to the nature of the technology used, I understand that tele-health psychotherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to tele-health psychotherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of California. (This is a legal requirement for psychotherapists practicing in this state under a CA license.)

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to tele-health psychotherapy. As such, I understand that the 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 I have discussed with **Christina Ingenito** and agreed to in our initial session(s).

4. I understand that there are risks and consequences of participating in tele-health psychotherapy, 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.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that tele-health psychotherapy-based services and care may not be as complete as face-to-face services.

7. I understand that I may benefit from tele-health psychotherapy, but that results cannot be guaranteed or assured. I understand that 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.

8. I accept that tele-health psychotherapy 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 tele-health psychotherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in tele-health psychotherapy. I am responsible for:
    A. Providing the necessary computer, telecommunications equipment and internet access for my tele-health psychotherapy sessions, and
    B. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele-health psychotherapy session. It is the responsibility of the psychotherapist to do the same on their end.

10. I understand that 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 tele-health psychotherapy:

Client's Signature: _____ Date_____

Therapist's Signature: _____ Date_____

CHRISTINA INGENITO, LCSW LCS11949