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## **CONSENT FOR TELEHEALTH CONSULTATION**

I, \_\_\_\_\_, hereby consent to engage in teletherapy with Diane Ghiron, PsyD. 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.

Telehealth by Doxy.com is the technology service we will use to conduct telehealth videoconferencing appointments. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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

1. I, the client, need to be a resident of California. (This is a legal requirement for psychologists 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 teletherapy. 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 are described in the general Consent Form I received at the start of my treatment with Diane Ghiron, PsyD.
4. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

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5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that Diane Ghiron PsyD. or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation and finish the session by phone. The phone I would prefer to use in that situation is:

\_\_\_\_\_.

6. I accept that 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, Diane Ghiron, PsyD., will recommend more appropriate services.

7. 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 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.

8. 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 telehealth:**

Client's Signature: \_\_\_\_\_ Date \_\_\_\_\_

If Minor, Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_