Sandra L. Stultz, LMFT

CA License NO. MFC 43047

Specializing in therapeutic services for Adults, Children, Adolescents, Couples and Families

Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Sandra L. Stultz, LMFT, as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications. I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Sankofa Holistic Counseling Services, that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to face. I

understand that if my therapist believes I would be bettered served by other interventions I will be referred to a mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, and as with in person therapy, results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, and Google audio/video systems are not 100% secure and may have issues with wi-fi connectivity. All attempts to keep information confidential while using these systems will be made. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Sankofa Holistic Counseling Services, or its staff liable for gathering or use of client information by these service providers.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all my questions regarding the above matters have been answered to my approval.

6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should 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 threating 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.

_____ Client name Date

_____ Signature of client/parent/guardian Date

_____ Relationship to Client

_____ Signature of Psychotherapist Date