CMM Mental Health & Family Therapy, Inc.
29995 Technology Dr., Suite 101
Murrieta, CA 92563
Phone (951)249-7288 Ext 101 Fax (951) 654-3526
http://www.cmmmentalhealth.com

Consent and Statement of Understanding Regarding Telehealth Sessions

Name _____ Date of Birth _____

Home Address_____

City_____State_____Zip_____

Email_____ Phone _____

Emergency Contact name:_____

Emergency Contact number:_____

I hereby authorize CMM Mental Health & Family Therapy, Inc. and it's therapists to use Telehealth technology for our therapy sessions. Telehealth is a service provided via audio/visual, two way, real time communication, using a private, Telehealth encrypted software that it is HIPAA compliant, please note that FaceTime, Messenger and Skype are not used for Telehealth.

I understands that I am responsible for providing my own communication device (computer, phone, tablet, etc).
I understand that under any circumstance I will not record any content of the session conducted via Telehealth nor my therapist.
Telehealth is confidential just like to face-to- face therapy, limitations to confidentiality also apply and also I authorize my therapist to contact my emergency contact (above) if she believes I may be in any danger during the therapy session.

I understand that there are risks and consequences from Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that there is a possibility that our technology may fail during a Telehealth session, and that there may be an interruption; a need to continue by phone; or a need to reschedule.

I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will discuss this further with my therapist.

I understand that my therapist is only licensed in the State of California. I understand that if I must travel or move out of the state, I will need to obtain other mental health services.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event, or condition on which this content expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date initiated.

I understand that I may benefit from Telehealth, but that results cannot be guaranteed or assured.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

This Telehealth consent it is an addition to the information already signed in the Client Policy Statement And Consent for treatment.

Signature of Client_____Date_____

Client Signature (age 14 and over)

_____Date_____

Parent/Guardian of Minor

_____Date_____