MARY E. SYLVESTER, L.M.F.T.
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INFORMED CONSENT FOR TELEHEALTH

I _____(your name) hereby consent to participate in psychotherapy via telephone and/or the internet (hereafter referred to as "telehealth") with Mary E. Sylvester, LMFT.

I understand that "telehealth" allows my therapist, Mary E. Sylvester, LMFT, to diagnose, consult, treat, transfer medical data and educate using interactive audio, video or data communication regarding my treatment. I understand that my therapist uses the telehealth site: Doxy.me: https://doxy.me, (844) 436-9963.

I understand that I have the following rights under this agreement:

I have a right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my treatment therefore is confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child abuse, elder abuse and dependent adult abuse as well as threats of violence I may make towards a reasonably identifiable person or against the United States as outlined in the Patriot Act of 2001, Section 215. I also understand that if I am in such mental or emotional distress to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment has been found to be effective in treating a wide range of emotional and mental health issues, both individual and relational, there is no guarantee that all treatment will address the issues clients have sought assistance. Thus, I understand that while I may benefit from telehealth, results cannot be assured.

I further understand that there are risks unique and specific to telehealth, including, but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical

Please Initial: _____

failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that I have a right to access my psychotherapeutic records and copies of medical records in accordance with applicable California law.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment fully answered.

Client Signature:_____ Date: _____

Mary E. Sylvester, LMFT
Psychotherapist Date: _____