Dr. E. Hitchcock Scott's Telecounseling/Telepsychotherapy Informed Consent Form 2020

I [name of client],______________________________ hereby consent to engaging in telecounseling/telepsychotherapy with E. Hitchcock Scott, PhD, NCC, Licensed Professional Clinical Counselor 917, LAADC (non-governmental license in CA), ATR-BC (registered art therapist), (PO Box, 6806, Malibu, CA, 90264, 310-880-9761), as part of my psychotherapy and/or chemical dependency counseling. I understand that "telecounseling/telepsychotherapy," includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, billing, communication in-between sessions, and education using interactive audio, telephone, video, email, texts, or data communications. I understand that telecounseling/telepsychotherapy also involves the communication of my counseling/addiction/medical/mental health information/sexual and gender orientation, both orally and visually, to you or health care practitioners located in California, or outside of California, depending upon licensure, upon need, and releases. By signing this agreement, I am also giving permission for my personal communications with this therapist to be sent via telephone, email or text. I am authorizing diagnostic coding and billing information to be sent via email. This author requests that you do not send texts (which are not HIPAA compliant) to this author for any reason. By signing this document, if you send emails or texts to this author, even if she initiates or responds, this author is not liable for potential privacy, confidentiality, or privilege breaches of protected personal and private information.

I understand that I have the following rights with respect to telecounseling/telepsychotherapy: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of my counseling/medical information also apply to telecounseling/telepsychotherapy. As such, I understand that the information disclosed by me during the course of my counseling is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telecounseling/telepsychotherapy interaction to researchers or other entities shall not occur, with the exception of rights granted in this document, without my written consent. (3) I understand that there are risks and consequences from telecounseling/telepsychotherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted or intercepted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telecounseling/telepsychotherapy based services and care may not be as complete as face-to-face services. I also understand that if my counselor believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services), I may be referred to another health care provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling or psychotherapy, and that despite my efforts and the efforts of my counselor or psychotherapist, my condition may not be improve, and in some cases may even get worse. (4) I understand that I may benefit from telecounseling/telepsychotherapy, but that results cannot be guaranteed or assured. (5) I understand that I have a right to access my counseling/medical information and copies of counseling/medical records in accordance with California law.

I have read and understand the information provided on this page regarding telecounseling, telepsychotherapy, or teleaddiction treatment which in this case includes periodic telephone sessions with a face to face client. I have discussed it with my counselor/therapist, and all of my questions have been answered to my satisfaction.

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Signature of Client/Patient/Parent/Guardian/or Conservator and DATE. If signed by other than client/patient indicate relationship. Please print full name, address, phone number and email address.