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**MENTAL HEALTH MATTERS
Franchesca Joubert Haselrig, LMFT. License # 113493**
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**INFORMED CONSENT TO TELEHEALTH**

I hereby consent to engaging in telehealth therapy services with Franchesca Haselrig, LMFT (therapist #113493 ), with Mental Health Matters as part of my therapy. I understand that “telehealth” (online counseling) includes the use of my therapist using Therapy Notes software to provide secure HIPPA compliant interactive audio, video, or data communications to enable the therapist and the patient at different locations to see and or talk with each other for a face to face session through a desk top computer, laptop computer, tablet or cell phone for consultation, treatment, emails, telephone conversations, and other medical/mental health information.

1. I the patient agree I am a resident of the State of California.
2. I the patient agree I am using this modality to visit with the therapist in their California office/home (Private/Secure Area).
3. I the patient will be responsible for the following:
	1. Providing necessary telecommunications equipment and internet access for teletherapy sessions,
	2. Securing or encrypting protected health information (PHI) transmitted to or stored on computer/telecommunications device.
	3. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for teletherapy sessions.
	4. I the patient will provide my full name and address of present location at the beginning of each telehealth session to the therapist.
4. I can, if I choose to withdraw or withhold consent from teletherapy services at any time. I also have the right to terminate treatment at any time.
5. The laws that protect the confidentiality of my mental health records/information also apply to telehealth services. Our teletherapy exchange is strictly confidential. Any information I the patient choose to share will be held in the upmost strictest confidence. Just like face-to-face clients, I the patient will not release information to anyone without the therapist approval first unless I the patient am required to do so by California law. In California, therapists are required to notify authorities if the therapist becomes convinced a patient is about to physically harm someone or if they are abusing or about to abuse children, the elderly, or the disabled.
6. I the patient 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 and myself, that the transmission of my mental health information could be disrupted or distorted by technical failure or the transmission or my mental health information could potentially be interrupted by unauthorized persons.
7. I the patient understand that while email may be used as a form of communication with the therapist that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that have the ability to obtain and disseminate information you wish to keep private.
8. I the patient understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
9. I the patient will be asked by the therapist to confirm my full name and home address and the address of my location during session before session begins.

In signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I the patient am in crisis or in an emergency, I the patient will immediately call 911 or go to the nearest hospital or crisis walk-in center the therapist provided. In signing this document, I the patient understand that emergency situation may include, but are not limited to the following; my thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I the patient am in a life threatening or emergency situation, and/or are not safe. In signing this document, I the patient acknowledge I the patient have been informed that if I the patient feel suicidal, I am to call 911, go to the local Crisis Center “Valley Star Crisis Walk-In Crisis Center at 12240 Hesperia Road, Suite A Victorville, CA 92395 and/or call at (760) 245-8837, or call the National Suicide Hotline at 1-800-784-2433.

I the patient have been informed of and understand the information provided above by my therapist Franchesca Haselrig, LMFT via phone regarding consent for telehealth therapy. I the patient have discussed these points with my therapist, and all my questions regarding the above matters have been answered to my satisfaction and I the patient agree to consent and agree to its terms.

“Patient agreed/ provided verbal consent to Telephonic or Face to Face (video) sessions and is unable to sign.”

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of the patient), am at the address of

Address: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at the time of treatment.

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date of intake consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Franchesca Haselrig, LMFT# 113493 \_

Therapist Name/License Number