Kari Berquist, Ph.D., BCBA-D

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Telehealth Informed Consent Form

Client/Child's Name: _____ D.O.B: _____

I _____hereby consent to my child, _____ and family members engaging in telehealth with Kari Berquist, Ph.D, BCBA-D as part of my child's psychological treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical and clinical data, and education using interactive audio, video, or data communications, including the use of telephone, cellular phone, Internet, email, or text. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telehealth:
(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 medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy 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 telehealth interaction to researchers or 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 my psychologist, that: the transmission of my child's medical/mental 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. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychologist believes I would be better served by another form of psychological services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of

psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California state law.

(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 or my child are in crisis or in an emergency I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. By signing this document I understand that emergency situations include if I or my child have thought about hurting or killing either another person or myself/themselves, if I or my child have hallucinations (see or hear things others don't, if I have delusions=beliefs others may consider unrealistic), if I or my child am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I or my child am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I or my child feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

I have read and understand the information provided above. I have discussed it with my psychologist, and any of my questions have been answered to my satisfaction. By my signature below, I understand the risks and benefits related to the use of telehealth services and agree to utilize and participate with the use of telehealth services with the psychologist named above.

_____	_____
Printed name of legal guardian	Date
_____	_____
Signature of legal guardian	Relationship to client