BAKER
FAMILY THERAPY
BOBBIE BAKER, MA, LMFT, RPT
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TELEHEALTH INFORMED CONSENT

This document is designed to provide information pertinent to engaging in Telehealth Services with Bobbie Baker, psychotherapist at Baker Family Therapy. Your signature on this form indicates that you have acknowledged, understand and agree that Bobbie Baker will provide Telehealth mental health therapy according to this Telehealth Informed Consent. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with Bobbie Baker before obtaining Telehealth services.

I understand that Telehealth (also referred to as e-therapy, teletherapy, telemedicine, virtual therapy, video therapy, or teleplaytherapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of the client's medical information also applies to Telehealth. Client confidentiality with Telehealth services are exactly the same as the rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by the client during the course of therapy, therefore, is generally confidential, with the following exceptions:

- Mandatory reporting of child, elder, and dependent adult abuse.
- Any threats of violence the client may make towards a reasonably identifiable person.
- If the client is in such mental or emotional condition to be a danger to self or others, therapist has the right to break confidentiality to prevent the threatened danger.
- Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.
- If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

Therapeutic treatment for mental health, both in person and through Telehealth services, has been found to be effective in treating a wide range of clients, and individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Telehealth services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, my therapist Bobbie Baker can be contacted at (206) 660-9562***. By signing this consent form, I am acknowledging that I know how to contact my provider in case of a disruption or emergency.***

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur by myself, my child or by Bobbie Baker.

I also understand that the Telemedicine appointment time is reserved exclusively for me/my child. If we cannot attend a scheduled appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. If I do not provide 24-hour notice for non-emergency reasons, late cancellation fees will apply.

If the client is under 13 years old, the child's parent or guardian agrees to help support their child in finding a confidential and private space for telemental health sessions. The parent also agrees to be physically present at the location and available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested. The parent will provide the phone number where they can be reached during each session.

I understand that I have the right to withhold or withdraw my consent to the use of Telehealth services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Bobbie Baker at 206-660-9562 or bobbie@bakerfamilytherapy.net.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.
My signature below indicates that I have read this Telehealth Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telehealth Services via an online HIPAA compliant telemedicine platform with the clinician listed below:

Client Name (printed): _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Therapist's Signature: _____

Date:_____