

## **Debbie G. Ramirez, LCSW**

**8055 W Manchester Ave., Ste 450**

**Playa Del Rey, CA 90293**

**(310) 704-6854**

### **Informed Consent for Telehealth Mental Health Services**

Please read the following video therapy consent and sign below.

1. I understand that I am about to engage in a video session with my provider, Debbie G. Ramirez, LCSW. The services are being provided to me at the rates outlined in the informed consent form for individual, couples or family therapy and are consistent with an in-person session rates.
2. I understand that video conferencing technology will not be the same as an in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
3. I understand the potential risk to this technology, include interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate for the situation.
4. My provider agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform the provider if there is another person present during the session.
5. I understand that there are alternatives to a video therapy session available, including the option of finding another provider to see in-person in my area.
6. I understand that I can direct questions about this video therapy session at any time to my provider.
7. I understand that this consent will last for the duration of my relationship with my provider, including any additional video therapy sessions I may have; I can withdraw my consent for a video therapy session at any time.
8. I understand that same confidentiality protections, limits of confidentiality and rules around my records apply to a video therapy session as they would to an in-person session.
9. I agree to work with my provider with a safety plan, including one or two emergency contacts, in the event of a crisis during one of our sessions.
10. I understand that my provider may decide to terminate video therapy sessions, if they deem it inappropriate for me to continue therapy through video sessions. My provider will provide a referral for in-person care if indicated.
11. The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I understand its contents including the risks and benefits of the procedure(s).
- That I have had the opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to participate in video therapy session(s) with Debbie G. Ramirez, LCSW.

**Print Name (Client) Date**

**Signature (Client) Date**

Print Name (Additional Client) Date

Signature (Additional Client) Date

Print Name (Additional Client) Date

Signature (Additional Client) Date

Provider's Signature Date