CAMFT
MEMBER OF THE CALIFORNIA ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS

kathy looper
CHRISTIAN-BASED CLINICAL THERAPIST

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TELETHERAPY INFORMED CONSENT FOR COUNSELING

Introduction

California law requires licensed therapists to provide their clients with information that allows them to make informed decisions regarding their participation in therapy. This document serves as an agreement between Kathy J. Looper, CDWF, LMFT, and any person or persons who seek Counseling services from her. This document is meant to be both informative and consensual in nature and is legally binding once it has been signed and dated. Both client and therapist consent to the terms of this agreement as stated below.

Therapist's Approach

Ms. Looper has a Master's Degree in Psychology, with an emphasis in Marriage & Family Therapy. She is Licensed with the Board of Behavioral Sciences in California, registration # BBS114064. Ms. Looper's approach to therapy is rooted in Cognitive Behavioral Theory as well as Solution Focused Theory; other modalities may apply including The Daring Way™, based on the research of Brené Brown, LCSW, Ph.D. All approaches to therapy are based in empirical scientific theory. As an ordained license minister, Ms. Looper also offers integrated biblical principles coupled with evidenced-based theory for a Christian based approach to therapy _____ Client Initials.

Teletherapy Parameters:

I _____hereby consent to engage in teletherapy with Kathy Looper, LMFT. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or

consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Psychotherapy Services Agreement I received with this consent form.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Ms. Looper, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if Ms. Looper believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will make a face-to-face appointment with her or be referred to a professional 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 therapist, my condition may not improve, and in some cases may even get worse
5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. I accept that teletherapy does not provide emergency services. During our first session, Ms. Looper and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
8. I understand that while email may be used to communicate with Ms. Looper, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

Benefit and Risks

People seek therapy for a multitude of reasons. Therapy is meant as a means to help others. Often a new perspective can help a great deal. As therapists, our motto is "do no harm." The goal of therapy is a reduction of stress; anxiety, distress or any other psychological problem the client is seeking help with. These problems can include a mental health issue, personality issue, environmental issue, family issue, school issue, relationship issue and even religion issues.

In most cases, therapy can improve one's sense of well-being and their relationships. In some cases people obtain little or no benefit from therapy and risk getting worse. Therapy can often lead to unsettled, unspoken emotions that surface as a result of conversations and interventions within the process. The outcome of therapy is subjective and can only be determined by both client and therapist's degree of participation and commitment.

Therapist Responsibilities

As your therapist, I will guide you along your journey with information, choices and new perspectives in managing your given situation or circumstance. I will inform you of possibilities and risks and walk you through difficulties in a professional manner. Sessions are 55 minutes in length and your first session will be used by both parties as an informational session to answer any possible questions either might have. The nature of your visit will also be discussed at that time as well as your possible length of sessions.

It is my obligation and duty to provide you with professional services and maintain ethical boundaries in every situation throughout the therapy process. If there is ever anything you do not understand or need further clarification on please feel free to ask.

It is also my duty to maintain client confidentiality as provided below. There are situations in which I am mandated report and those are also specified below.

1. I am required by law to report any Child Abuse, Elder Abuse, Spousal Abuse, Perceived harm to self or Perceived harm to others.
2. I will not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.
3. There may be a time I use client and/or materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with written consent or when appropriate steps have been taken to protect client identity and confidentiality.
4. I will store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.
5. When consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

Record Keeping

I will take notes during the therapy session. This is done so that I may expand upon my thoughts and questions throughout the session. These notes constitute clinical business records which by law, therapists are required to maintain. Such records are the sole property of the therapist. Should you or your representative request a copy, you may do so in writing. Therapists reserve the right, under California law to provide a treatment summary in lieu of actual records. I may also refuse to release

records under certain circumstances but may provide a copy of the record to another treating patient provider.

Fees & Cancellation Policy

Regular sessions are billed at $150.00 per 55 minutes. Initial intake assessment is billed at $225.00 and is a 90 minute session. If for any reason you need to cancel an appointment, you may do so with at least a 24 hour notice. Clients who do not give a 24-hour notice will be charged their regular rate of $150.00. Cancellation Policy is strictly enforced. If paying electronically using debit or credit card, a 5% fee will be added _____ Client Initials.

Email & Text Messaging

I have been made aware of the limitations and possible benefits of communicating with my counselor for routine matters of communication like scheduling, billing, or non-emergency routine communication. I understand that there are risks to confidentiality and that my counselor cannot assure confidentiality if I choose to communicate with e-mail or text messaging. I have had an opportunity to ask questions regarding e-mail or text messaging communication. The questions, (if applicable), were addressed to my satisfaction by my counselor.

I give permission to communicate via **e-mail** _____ Client Initials

and/or via **text messaging** _____ Client Initials

I **DO NOT** give permission to communicate via e-mail or text messaging _____ Client Initials.

Agreement of Services

After reading and acknowledging the above information, the signatures below serves as an agreement between _____ and Kathy Looper, CDWF, LMFT, to begin the therapy process. I understand that fees are due at the time of service and I understand the confidentiality and privacy matters as outlined above. Furthermore, I understand that I may discontinue services at anytime for any reason. By signing below, I willingly consent to therapy services via teletherapy with Kathy Looper, LMFT.

_____

Print Signature Date

Phone:_____Email:_____

DOB:_____Address:_____

_____

_____

Kathy Looper Signature Date