RACHEL BERNSTEIN, LMFT, MS.Ed

16255 VENTURA BLVD
SUITE 806
ENCINO, CA 91436

TELEHEALTH INFORMED CONSENT FORM

Please read and sign this form to provide your consent to meet virtually with Rachel Bernstein via Telehealth.

I agree to the following:

- I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. This right to confidentiality extends through the Telehealth service.

- I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

- I understand that miscommunication between myself and my therapist may occur via Telehealth.

- I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

- I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

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- I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

- I have discussed the fees charged for Telehealth with my therapist and agree to them.

- I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I acknowledge that I have read the above information. I will direct any further questions to Rachel Bernstein.

Please type your name in the boxes below to sign this document.

First Name

Last Name

Date (*mm/dd/yyyy*)