Bridget Fanning-Ono, PsyD, Lic. #1629

1020 SW Taylor Street, Suite #245

Portland, OR 97205

(503)544-1868

www.drfanningono.com

drfo@me.com

TELEHEALTH INFORMED CONSENT FORM

I _____ (name of the client/patient) hereby consent to engaging in telehealth with Bridget Fanning-Ono, PsyD, licensed psychologist, as part of my psychotherapy.

I understand that "telehealth"(a/k/a online counseling) includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telehealth:

1. I have a 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 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 and 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 any 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 psychotherapist, that: the transmission of m medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or 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.

Finally, I understand that there are potential risks and benefitsassociated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, 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. By signing this document, I agree that certain situations including emergencies and crises areinappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol in a manner which are threatening my safety.

By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433.

I have read and understand the information provided above. I have discussed any points that were not clear with my psychotherapist, and all my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent and agree to its terms.

_____ _____

Print Name Date

_____ _____

Signature of Patient/Client or Personal Representative Date

_____ _____