Traci L. Wallace, Ph.D.
Licensed Psychologist
PSY 14644

TELEHEALTH WRITTEN CONSENT FORM FOR PSYCHOTHERAPY

This document constitutes my written consent to obtain "telehealth" services from Traci Wallace, Ph.D., a psychologist located in Santa Monica, California. I understand that telehealth is a mode of delivering health care services (in this case, psychotherapy) to facilitate the diagnosis, treatment, care, management and self-management of my health while I am at an "originating site" (my home or office) and Dr. Wallace is at a "distant site" (her office in Santa Monica, California).

I understand that Dr. Wallace and I will have "synchronous interaction" meaning real-time interaction via use of the internet or telephone. I further understand that while Dr. Wallace and I expect our communications to be secure and confidential Dr. Wallace cannot insure with absolute certainty the security of such internet or telephone communication and I am willing to accept this risk. Specifically in regard to telehealth sessions accomplished through the internet, it is understood and agreed that Dr. Wallace is not an expert in electronic communications and, though using a HIPAA-compliant platform, does not control how the service provider manages data that is transmitted.

Confidentiality still applies to telehealth sessions and therefore neither party will record the session. I will make every effort to participate while in a quiet, private space that is free of distraction during the session.

Since Dr. Wallace is not physically present at or near my "originating site", I further understand that if an emergency or life-threatening situation were to arise I may not be able to reach Dr. Wallace in such circumstances and I therefore agree that I will, in such circumstances, call 911 or go to my nearest hospital emergency room. I understand that this is another of the risks involved in telehealth psychotherapy as defined in the California Business and Professions Code (Section 2290.5 as updated 1/23/12) and that Dr. Wallace requires me to agree to and sign this document in order to receive telehealth psychotherapy.

Patient's Name (printed) _____

Signature _____

Date _____

3101 Ocean Park Boulevard, Suite 311 Santa Monica, California 90405

310-425-5175