

Mary Jane DeWolf-Smith, RN,PHN, LMFT

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Consent for Telehealth

Mary Jane DeWolf-Smith, LMFT hereinafter referred to as “my therapist”, provides Telehealth psychotherapy.

I understand that with Telehealth Sessions:

1. Health Information confidentiality outlined in the HIPPA agreement and Consent to Treatment applies.
2. Telehealth sessions are to proceed with therapist and patient(s) in quiet, private locations.
3. Potential risks may include unpredictable technical difficulties.

I/we, the undersigned, hereby authorize *my therapist* to provide Telehealth via the Doxy.me secure Telehealth platform.

This consent shall remain in effect for 1 year or until ____/____/____.

I understand that either my therapist or I may discontinue Telehealth if Telehealth is not deemed adequate.

Patient or Guardian’s Signature:

Printed Name: _____ Date: _____

Patient or Guardian’s Signature:

Printed Name: _____ Date: _____

Therapist’s Signature: _____

Mary Jane DeWolf-Smith, RN, LMFT 35490

Date: _____