Candace Dale Mckenzie Counseling LLC
Treatment Agreement

Candace Dale Mckenzie GA LMFT
4880 Lower Roswell Rd Ste 165, Suite 143, Marietta GA, 30068
404 620 1540 / ***cdmcounseling@gmail.com***

This ***Telemedicine Informed Consent*** is in addition to the Treatment Agreement. If you have any questions about this additional agreement, please do not hesitate to reach out. This agreement once signed constitutes and informed agreement about our work together online, any confidentiality boundaries, and inherent risks, though rare, of using this medium.

I, _____ hereby consent to engaging in telemedicine with Candace Mckenzie, CA and GA LMFT, and currently reside in the state of **CA and GA**.

I understand that telemedicine 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 telemedicine also involves the communication of my medical/mental health information, both orally and visually.

I understand that I have the following rights with respect to telemedicine and agree to these items below:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment in regard to "in person" therapy.

(2) I have the right to confidentiality, and the laws that protect my medical information also apply to telemedicine. 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 my mental or emotional state is an issue in a legal proceeding.**

(3) Further, I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(4) I understand that there are risks and consequences from telemedicine, including but not limited to, the possibility, that despite reasonable efforts on the part of my psychotherapist, the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be

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interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

(5) In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service.

(6) 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 psychotherapist, my condition may not improve and in some cases may even get worse.

(7) On the other hand, I also understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(8) I understand that I have a right to access my medical information and I understand that I have a right to access my medical information and copies of medical records in accordance with California and Georgia law. The access is expanded more fully in the treatment agreement (informed consent.)

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Print Client Name_____

Signature of Client _____

Date _____

Signature of Therapist _____

Date _____