

**TELE THERAPY CONSENT FORM**

**Client Information:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email: \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contact Name:**

**Emergency Contact Number**

\_\_\_\_\_

\_\_\_\_\_

I hereby authorize Nicole Ashton, MFT to use telemedicine technology for our therapy sessions.

I understand that there is a possibility that our technology may fail during a teletherapy session, and that there may be an interruption; a need to continue by phone; or a need to reschedule. I authorize my therapist to contact my emergency contact (above) **IF** she believes I may be in any danger during the therapy session.

I understand that my therapist is only licensed in the state of California. I understand that if I must travel or move out of state, I will need to obtain other mental health services.

I understand that if I give less than 24hour notice to cancel an appointment, I will be billed a \$200 cancellation fee.

I understand that if I choose to use insurance to pay for sessions, I am permitting another party to have access to requested information.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event or condition on which this content expires. If none stated, and if no prior notice of revocation is received, this consent will expire one year after the date initiated. If there is no contact and no appointments scheduled for 60 days, my therapy file will be considered closed.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_