Loriene Honda, Ph.D.
Licensed Psychologist
PSY #19126

**CLIENT CONSENT AND LIMITS OF CONFIDENTIALITY
RELATED TO TELE-THERAPY SERVICES**

My signature below confirms that I am in full agreement to participate in tele-therapy services with Loriene Honda, Ph.D. via a video-conferencing platform. I am fully aware that doing so may include some potential risks to my privacy and confidentiality, such as individuals overhearing my conversation in the location in which I am receiving the services. I know that Dr. Honda will make every effort to maintain and protect my privacy in her therapeutic office setting, including establishing a volume level audible only to her.

I am also aware of different potential privacy risks using tele-therapy services, such as an unauthorized taping of sessions by a third party without my or Dr. Honda's knowledge – or when affiliates associated with the tele-therapy platform of choice are potentially given access to my digital information unbeknownst to Dr. Honda and myself, for cross-advertising and data-selling purposes.

I understand that tele-therapy may not be as optimal as when services are provided in person; however, I am fully accepting of the potential limits inherent in this alternative method. I understand that it's best to use a secure internet connection rather than public/free Wi-Fi to protect my confidentiality. If I am a minor, Dr. Honda has the permission of my legal guardian to participate in tele-therapy sessions, as indicated in consent signatures provided below. I am also listing below, for our convenient reference, an emergency contact and the closest ER to my location in the event of a crisis.

I will confirm with my insurance company that tele-therapy sessions will be reimbursed; if they are not reimbursed, I know that I am responsible for full payment.

I confirm that Dr. Honda has recommended alternative "in-person" options for therapy services such as referrals to therapists local to my current residence and as-needed periodic therapy sessions with Dr. Honda when I am back in Davis or when I feel comfortable meeting in the office. My preference at this time, however, is to participate in this "therapy by webcam (tele-therapy)" option.

I accept Dr. Honda's HIPAA and Office and Treatment policies, which indicate, among other issues, the limits of confidentiality in my treatment, my right to withdraw from services at any time, and that information obtained from Dr. Honda's services cannot be shared for any research purposes without my consent.

_____ Client	_____ Date
_____ Legal Guardian (if client is a minor)	_____ Date
_____ Emergency Contact (print name)	_____ Phone number (inc area code)
_____ Local Medical Emergency Facility (list name)	_____ Phone number (inc area code)