Telehealth Services

After reading each statement please initial:

_____ Client consents to having therapy sessions via telehealth (video or telephone sessions).

_____ Recording of the therapy sessions is prohibited.

_____ Driving is prohibited during therapy sessions.

_____ Due to the potential risks and limitations of receiving treatment via telehealth, client will inform therapist if having any thoughts, actively or intermittently related to suicide, homicide OR harm to self and/or others.

_____ Client is aware of this therapist's license type & number: Ruth Lynch, LMFT CA 47327.

_____ Client agrees to give their current location at the beginning of each therapy session. This will allow Ruth Lynch, LMFT, if needed, to make reasonable efforts to ascertain the contact information of relevant resources in the patients geographic area.

Any questions regarding the above information can be discussed with Ruth Lynch, Licensed Marriage & Family Therapist. I understand, and have read the above information:

Print Name: _____ ***Date:***_____

Signature: _____

If Minor, Guardians Signature:_____

Relation to Client:_____

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