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### **CONSENT FOR AUDIO AND/OR AUDIO CONSULTATION**

I understand that my health care provider wishes me to engage in a video and/or audio sessions.

My health care provider explained to me how the video conferencing technology will not be the same as a direct client/health care provider visit due to the fact I will not be in the same room as my provider.

I understand that a video/audio session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that my health care provider or I can discontinue the video/audio session if it is felt that the video/audio is not adequate for the situation.

I have had a direct conversation with my provider during which I had the opportunity to ask questions in regards to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language I understand.

[Zoom.us](#) is the technology service we will use to conduct videoconferencing appointments. It is simple to use and there are no passwords required to log on. I will send an invitation that each person will receive by email.

By signing this document I acknowledge:

[Zoom.us](#) is not an emergency service and in the event of an emergency, I will use a phone to call 911.

Though my provider and I may be in direct virtual contact, [Zoom.us](#) does not provide any medical or healthcare services or advice including, but not limited to emergency or urgent medical services.

[Zoom.us](https://zoom.us) facilitates videoconferencing and is not responsible for any healthcare, medical advice, or care.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend this appointment.

I understand my provider may make additional videoconferencing services should the need arise.

I further understand that my provider has conducted due diligence to ensure these services are HIPPA compliant and sufficiently secure to warrant use for therapy services.

I certify that I have read this form or had this form explained to me.

I fully understand the contents including the risks and benefits of the procedures.

I have been given ample opportunity to ask questions and that these questions have been answered to my satisfaction.

\_\_\_\_\_  
Print Name: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature: Patient (Parent/Guardian)