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INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we want to explain the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- We use the encrypted-version of Zoom to conduct telehealth. We will need to email you a link to join the meeting; email communication is not always a secured medium.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

CONSENT AGREEMENT

I have read the terms and conditions outlined in this document. I understand them, and agree to be bound by them.

Patient (or Parent/Guardian of a Minor) Signature: ______________________________

Printed Name: ______________________________ Date:______________

Parent 2 Signature*: ______________________________

Printed Name:______________________________ Date:______________

*Both parents must consent to treatment of a minor in cases where parents are in the process of separating, are separated, have joint, or sole legal custody.

Therapist Signature: ______________________________ Date: ______________