PSYCHOLOGY
CONSULTANTS ASSOCIATED

Informed Consent for Teletherapy

By signing below I am consenting to engage in teletherapy as an adjunct form of therapy at Psychology Consultants Associated (PCA). I understand that teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations, and/or education using interactive video, audio and data communications. I understand that teletherapy also involves the communication of my medical and mental health information, both visually and orally.

I understand and agree to the following terms:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential with the exceptions that are outlined in the general Terms of Treatment that I have already signed.

3. I understand that there are risks and consequences from teletherapy due to unforeseen circumstances related to the use of technology. All reasonable efforts will be made to mitigate these risks, however the possibility of disruptions to our transmissions because of technical problems, interruptions to sessions by unauthorized individuals, or access to my medical record by unauthorized persons are all possibilities that exist.

4. I understand that teletherapy is potentially not as effective as face to face sessions. If my provider feels that teletherapy is not the best option for treatment for me, other forms of treatment will be considered, which may include referral to another provider who can provide face to face sessions. Additionally, in-person and teletherapy carry similar risks and benefits and despite my provider's best efforts professionally, improvement in my condition cannot be guaranteed.

5. I understand that teletherapy is not an option for emergency situations. My provider will discuss with me an emergency plan before teletherapy begins so that in a situation where immediate intervention is necessary, assistance will be sought by providers where I am. If assistance is needed at times outside of scheduled teletherapy appointments, I will get help on my own which may include calling 911, going to a local hospital emergency room, and/or calling the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

6. I understand that I am responsible for:

* Providing the necessary computer or telecommunication equipment and internet access to allow for my teletherapy sessions
* Information security on my computer or telecommunication equipment
* Arranging for a location with appropriate privacy and lighting that is free from distractions or interruptions during our scheduled teletherapy appointments

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8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state laws.

9. I am aware that PCA will bill my insurance company for teletherapy appointments. PCA will check on my eligibility for these services and that I will be responsible for any costs associated with my appointments (e.g., copay, deductible, etc.) just as I would for in-person appointments. A credit card authorization form will be required to be completed so that my credit card can be billed following any teletherapy appointments regardless of whether I currently have copays or deductibles that I may have to pay.

10. By utilizing teletherapy services, I agree that I am engaging in services with a professional who is working within the state of Maryland and am participating in point of service therapy that will be occurring in Maryland. In other words, I will be using the internet and/or telephone to virtually travel to my provider's office. My provider will follow all of the applicable rules and regulations for licensure in the state of Maryland and may not necessarily follow all of the rules and regulations in the state in which I am located.

By signing below, I agree to these terms of treatment to participate in teletherapy. If there are any questions or concerns, please speak with your provider before signing this form.

Patient Signature: ______________________________ Date: ________________________

Patient Name (printed): __________________________

Provider/Therapist Signature: ____________________ Date: _________________________