Meredith Cary, PsyD
Contact: (703) 447-8011 DrCary@mac.com

INFORMED CONSENT : Please sign and date at bottom

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and neither of us will record the session.
- We agree to use Doxy, the HIPAA-compliant (private/secure) video-conferencing platform for our virtual sessions. I will send you the link to it before our session.
- You need to use a webcam or smartphone during the session. To start our session, you ONLY need to click on the link I send you. No identifying data is kept by Doxy.
- 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, there is no charge if you notify me in advance by email within 48 hours (drcary@mac.com).
- The back-up plan (e.g., phone number where you can be reached) is: I will call you to restart the session or to reschedule it, in the event of technical problems.
    - Your phone number is _____.
- 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.
    - Your emergency contact _____
    - Emergency contact's phone _____
- You handle all communication with your insurance company. Even if they do not reimburse you, you are responsible for full payment.
- I can ONLY provide therapy if you are located (at the time of the visit) in a PSYPACT state.
- At the end of each session, you will enter your credit card info into Stripe, a secure third party system that is simple to use. Afterwards, I will send you the receipt/invoice in email.
- I will not be returning to face-to-face work. Telehealth is the only way I provide service.

Psychologist Name / Signature: *Meredith Cary, PsyD*

Patient Name / Signature: _____

Date:

Basic Information

Name _____

Address _____

Phone(s) _____

E-mail _____

ONLY provide your e-mail if it's OK to use it to (1) schedule, (2) send you supplemental info for sessions. I do not use email to consult about any issues.

_____

Date of Birth

Your Providers	Their Email or Address
Dr.	
Dr.	
Dr.	

_____

Who referred you?

It's professional courtesy for me to inform providers that you've begun CBT treatment with me. **NO details are shared**, unless specific collaboration is warranted. Please sign the attached authorization for this.

Thank You,

Meredith Cary, PsyD

Authorization Form
(in compliance with HIPAA)

Please sign and date at bottom

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the providers on the accompanying page.

I authorize Meredith Cary, PsyD to release information about the beginning and end of my treatment with her and other information that might be helpful to my other healthcare providers in my overall treatment.

This information should only be released to the healthcare providers I listed on Dr. Cary's "Information Sheet" as my providers.

I am requesting my psychologist to release this information for the following reasons: inform my providers that I'm receiving CBT (cognitive behavioral therapy) at the request of myself.

This authorization shall remain in effect until we have completed the brief, time limited psychotherapy sessions; however, except as provided below, the authorization shall be in effect no longer than 60 days from the date you sign this form.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Additionally, you may not revoke where an authorization is executed in connection with your obtaining a life or non-cancellable or guaranteed renewable health insurance policy, in which case the authorization shall be specific as to its expiration date which shall not exceed 2 years from the date of the policy; or where an authorization is executed in connection with your obtaining any other form of health insurance in which case the authorization shall be specific as to its expiration date which shall not exceed 1 year from the date of the policy.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

Meredith Cary, PsyD