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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

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 the HIPAA-compliant (private/secure) video-conferencing platform (https://doxy.me) for our virtual sessions, and I will explain how to use it.
- You need to use a webcam or smartphone during the session. You do NOT need to sign into the site or download a plugin to use the system. No identifying data is kept by the service.
- 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 should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- We are able to do therapy by telehealth as long as you are located in one of the 'participating Psypact States' (see: https://psypact.site-ym.com/page/psypactmap).
- At the end of each session while we're in the secure system (Doxy.me uses https://stripe.com), you will securely pay with your credit card. I will send you the receipt in email.
- As well, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person (when I resume office-based sessions at the end of the pandemic).

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) communicate about scheduling, (2) send you supplemental info for sessions.

_____
Date of Birth

Emergency Contact (in case a lack of safety issue arises)

_____
Name Contact Phone

Your (doctors) Providers Address (if you know it)

Dr. _____

Dr. _____

Dr. _____

_____
Who referred you?

It's customary to inform providers that you're in treatment with me. **Details are NOT shared**, unless YOU specifically permit me to do so. Please sign the attached so that I may notify your providers.

Thank You,
Meredith Cary, PsyD

Authorization Form
(in compliance with HIPAA)

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 - only upon your request.

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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

Meredith Cary, PsyD
703-447-8011