CDNC TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand (please initial to indicate that you have read and acknowledge each statement below):

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. _____

2. If a need for direct, face to face services arises, it is my responsibility to contact this office for a face to face appointment. I understand that an opening may not be immediately available and/or feasible at this time. **If I or my child are in crisis, I acknowledge that this provider is not available for crisis services and I should call 911, go directly to the nearest Emergency Department, or call the Utah Crisis hotline at 1-800-273-8255 (TALK).** _____

3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits. While this provider may not be able to see you immediately due to possible COVID community restrictions, a face-to-face appointment will be scheduled as soon as possible and/or other possible referrals will be provided to you. _____

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology. _____

5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. _____

- My provider will verify with me my location and all numbers at which I can be reached at the beginning of each session. _____
- A good emergency contact for me in case of a medical emergency is:

  _____
- A good emergency contact for me in case of a mental health crisis is:

  _____

6. My psychologist will respond to communications and routine messages through phone or email within 2 business days (Monday – Friday), unless she is out-of-town, with the dates and timeline for returning contact provided through these sources. If I am in crisis and my provider cannot be reached, I will use one of the crisis resources above. _____

7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications. _____

8. Precautions that may be taken to ensure that my communications are directed only to my psychologist or other individuals include:

- I understand that it is my responsibility prior to my session to be in a secure location, preferably without distractions and where confidentiality of information conveyed can be maintained ____
- My provider may ask me to confirm my ID verbally and visually at the beginning of the session _____
- My provider may ask me to scan the room with my camera to ensure that there are no other unauthorized people participating or listening to the session _____
- My provider may ask me to provide a code word at the outset of our session to let her know that it is NO longer safe to proceed using telehealth. I can use this code word at any point during the session. I will also make a plan with my provider prior to initiating services about how and when I will contact my provider to alert her that I am okay or need help. If my provider has not heard from me in the designated manner within _____ minutes, I acknowledge that she may find it necessary to contact the police or other authorities due to concerns about my safety. _____

9. My telehealth session will not be recorded or stored by my provider or by the telehealth service that my provider is using. *I also agree NOT to record our session in any form* without explicitly notifying my provider about my intent to do prior to any recording. My provider will discuss this with me, including the risks and concerns of doing so, but also preserves the right to terminate services and provide me with other possible referrals for continued care. _____

10. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent. _____

I have been advised of all the potential risks, consequences, and benefits of telehealth. My provider has discussed with me the information provided above. I have had the opportunity to ask questions about the information presented on this form and these have been satisfactorily answered. _____

My signature below certifies that I agree to participate in telehealth with the designated provider below. The purpose of these sessions may be for initial psychiatric intake/consultation, provision of testing results (feedback), testing/assessment, individual or family therapy, school consultations, and/or other services mutually agreed to between my provider and myself.

_____
Client Printed Name

_____ _____
Signature of Client or Legal Guardian Date

_____
Printed Name of Psychologist

_____ _____
Signature of Psychologist Date