**Roberta Hammond and Associates LLC**

**1344 Woodman Dr.**

**Dayton, OH 45432**

**Tele - 937-252-7336**

**Fax - 937-424-0280**

**INFORMED CONSENT CHECKLIST FOR TELEPSYCHOTHERAPY 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 telepsychotherapy 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 therapist 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 therapist 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 therapist, I may determine that due to certain circumstances, telepsychotherapy is no longer appropriate and that we should resume our sessions in-person.

Therapist’s Name / Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Patient’s Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_