**Informed Consent for Group Teletherapy Services**

This request hereby authorizes Jay H. Berk Ph.D. & Associates, to provide telehealth services for:

|  |  |  |
| --- | --- | --- |
| Myself | Guardians Full Name: | DOB: |
| My child | Clients Full Name | DOB: |

**Check one or both of the above options:**

**Clinician Information**

|  |
| --- |
| **ANY CLINICIAN AT JAY BERK PH.D. AND ASSOCIATES** |

I understand that teletherapy is the use of electronic information and communication technologies by a mental health care provider to deliver services to an individual when he/she is located at a different site than the provider, and hereby consent to Jay Berk Ph.D.. & Associates providing mental health services to myself or my child via teletherapy.

If applicable, my insurance carrier will have access to your medical records for quality review/audit.

I understand that most insurance covers teletherapy. I will be responsible for any payments, copayments or coinsurances that apply to my teletherapy visit. Please call your insurance regarding your specific coverage.

I understand that I have the right to withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent or in writing at any time by contacting in writing, Jay Berk Ph.D. and Associates. As long as this consent is in place (has not been revoked) Jay Berk Ph. D. and Associates may provide mental health services to me (my child) via teletherapy without the need for me to sign another consent form.

Teletherapy not be appropriate for all clients. If necessary, my clinician and I will discuss this issue.

I understand and agree to the following:

1. Due to the nature and modality of telehealth, Jay Berk and Associates cannot guarantee privacy and/or confidentiality; however, Jay Berk, Ph.D., will its best to follow all HIPPA guidelines and use a secure HIPPA compliant portal for all therapy sessions.
2. I agree to have ONLY the group member in the session.
3. The group member will be in a private area with no other individual(s) able to see or hear the session.
4. Under no circumstances shall there be any recording.
5. Disruptive individuals or those deemed by Dr. Berk as not appropriate will be dismissed.

**Signature of Patient or Parent/Guardian** Click or tap here to enter text. **Date:** Click or tap here to enter text.

*I understand that this agreement may be electronically signed. I agree that the electronic signatures appearing on this agreement are the same as handwritten signature for the purposes of validity, enforceability, and admissibility*.

***Please return a signed copy of the consent to*** [***Jberkphd@gmail.com***](mailto:Jberkphd@gmail.com)