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 distance counseling 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 psychotherapist will explain how to use it.

 You need to use a laptop with 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 distance counseling appointment, **you must notify the psychotherapist at least 24 hours in advance by phone/Text/email.** Failure to do so will result in your full session fee. If you miss your appointment you will be charged your full session fee.

 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 distance counseling sessions.

 As your psychotherapist, I may determine that due to certain circumstances, distance counseling

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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_