# Humanistic Counseling Center

Post Office Box 24242, Cleveland, Ohio 44124-0242

www.HumanisticCounselingCenter.com

Fax 216-896-0735

Phone 216-839-CARE (2273)


**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 Telepsychological Services (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the Telephone or video-conferencing platform selected for our virtual sessions, and the Clinician will explain how to use it.
- You need to use a webcam or smartphone during a video 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 Clinician 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 Telephone and video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.**
- Your Clinician may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

_____ _____

PRINT Clinician Name and Credential PRINT Patient Name

_____ _____

SIGNATURE: Clinician Name and Credential SIGNATURE of Patient or Legal Representative:

Date: _____ Date: _____