Compass Psychological Services, LLC
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Informed Consent for Telehealth Services

Thank you for choosing Compass Psychological Services, LLC. This document covers your rights, risks and benefits associated with receiving Telehealth Services, my policies, and your authorization. Please read this consent form carefully and sign. If you have any questions, please reach out to your therapist or Dr. Kara Zlotnick, Director of Compass Psychological Services, LLC.

TELEHEALTH DEFINED

Telehealth means the remote delivery of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The delivery method will be secured by two-way encryption and is HIPAA compliant.

BENEFITS AND LIMITATIONS

Potential benefits of telehealth include easier access to care and the convenience of meeting from a location of your choice.

Telehealth will not be the same as an in-person session with a therapist since you will not be in the same room as your therapist. In order to have the best results for this session, you should be in a quiet place with limited interruptions. Consider using a “Do Not Disturb” sign for your door. Our therapists will take every precaution to ensure a technologically secure and environmentally private psychotherapy session.

Potential risks to this technology include interruptions and technical difficulties.

IN CASE OF TECHNOLOGY FAILURE

Difficulties with hardware, software, equipment, and/or services supplied by a third party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online videoconferencing, your therapist will call you. Please make sure to have your phone with you and to supply us with that number. We may have to reschedule if there are problems with connectivity.

STRUCTURE AND COST OF SESSIONS

Insurance companies may or may not reimburse therapy via telehealth or at a lower rate than face-to-face sessions. Please contact your insurance company to learn about possible reimbursement.

CANCELLATION POLICY

If you are unable to keep an appointment, you must notify your clinician 24 hours in advance (with the exceptions of illness and emergencies). If you do not provide advanced notice, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this document, I acknowledge:

1. Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

CONSENT FOR TREATMENT BY TELEHEALTH

1. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

2. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

   I voluntarily agree to receive or have my child receive online therapy services for assessment, treatment, or other services and authorize my clinician at Compass Psychological Services, LLC to provide such treatment as are considered necessary and advisable. I may withdraw consent at any time.

   By signing this Informed Consent, I, the undersigned patient or parent, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. (Please contact your clinician or Dr. Zlotnick regarding any concerns or questions).

   I consent to the use of the following forms of communication via technology for myself or my child:

   - Telehealth services

   Signature_____

   Name_____

   Name of Patient _____

   Relationship to patient_____ Date_____/_____/_____

   For patients 14 years or older, please sign below.
   I consent to the use of the following forms of communication via technology for myself:

   - Telehealth services

   Signature_____Date_____/_____/_____