

**THE NORTH JERSEY CENTER FOR COGNITIVE BEHAVIORAL
THERAPY, LLC**
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**INFORMED CONSENT FOR TELEPSYCHOLOGY
(COVID-19)**

This Informed Consent for Telepsychology contains important information regarding psychotherapy using the phone or the internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is unable to meet in person.

Telepsychology, however, requires technical competence on both of our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. Examples include:

- **Risks to confidentiality.** Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy, but it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- **Issues related to technology.** There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Confidentiality

I will make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. There is always a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should take reasonable steps to ensure the security of our communications (e.g., only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Please note that the extent of confidentiality and the exceptions to confidentiality that I outlined in our Consent for Treatment and Office Policy Statement that you received at the outset of therapy still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Fees

The same fee will apply for telepsychology as for in-person psychotherapy. The same cancelation policy applies in that cancelations are billed if they are within 48 hours of the scheduled appointment. It is our understanding that given the coronavirus (COVID-19) situation, teletherapy sessions will be reimbursable. However, please contact your insurance company prior to our engaging in telepsychology sessions in order to verify this information.

Records

The telepsychology sessions should not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent (the Consent for Treatment and Office Policy Statement) that we agreed to at the outset of therapy and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ Patient Signature	_____ Printed Name	_____ Date
_____ Parent or Guardian Signature (if under 18 years old)	_____ Printed Name	_____ Date
_____ Therapist Signature	_____ Printed Name	_____ Date