

**INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES**

I, \_\_\_\_\_ hereby consent to participate in telepsychological health (telehealth) services with Sandra R. Koch, MA, LP as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. We have agreed to use telehealth with the start of COVID-19. This therapist has introduced herself and provided her credentials. We have disclosed our locations.

Prior to starting telehealth video-conferencing services, we discussed and agreed to the following:

\*We agree to use the video-conferencing platform selected for our telehealth sessions, and this therapist will explain how to use it. We will need to use a 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.

\*There are potential benefits and risks of telehealth services (eg. limits to patient confidentiality) that differ from in-person sessions. These include but are not limited to: disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. If there is an interruption in service, we will end and restart the session. If we are unable to reconnect within 10 minutes, please call this therapist at 612-823-2063 to discuss rescheduling.

\*We need a back-up plan (eg., phone number where I 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 my location, in the event of a crisis situation. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

\*I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

\*I will confirm with my insurance company that telehealth sessions will be reimbursed; if they are not reimbursed, I am responsible for full payment. I am also aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment or I will be charged in full for that appointment.

\*If I am not an adult, we need the permission of my parent or legal guardian (and their contact information) to participate in telehealth services.

\*I understand that this therapist may determine that due to certain circumstances, telehealth services are no longer appropriate and that we should resume our sessions in person.

\*I certify with my signature below that I have read, had explained to me where necessary, fully understand, and agree with the contents of this consent. I understand that I have the right to withdraw consent at any time with affecting my right to future care or services. I have had the opportunity to review this and ask any questions.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Provider Signature