Comprehensive Psychological & Wellness Center, LLC

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Telemental Health Informed Consent

This Informed Consent form is intended to inform you about our policies and procedures regarding Telemental Health Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, have acknowledged that you understand and agree that your therapist with the Comprehensive Psychological & Wellness Center, LLC will provide therapy to you according to this Telemental Health Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telemental health services, and agreed upon before any Telemental health services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telemental health services.

I understand that Telemental health services (also referred to as e-therapy, teletherapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemental health services. My rights to confidentiality with Telemental health services are exactly the same as my rights for in-person therapy services. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

Therapeutic treatment for mental health, both in person and through Telemental health services, has been found to be effective in treating a wide range of clients, though individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Telemental health services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemental health services, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs contact the office at 609-693-4343.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telemental health services interaction to any other entities shall not occur without my explicit written consent. Your therapist and Comprehensive Psychological & Wellness Center, LLC also agree to under no circumstances take any personally identifiable images from the session or store any of these images on personal or business devices from Telemental health services.

I also understand that my Telemental health services appointment time is reserved exclusively for me. We require that you provide us notice of cancellation 24 hours in advance. Failure to cancel your appointment with more than 24 hours notice, will result in you being charged a cancellation fee of $75. If you simply do not show up for an appointment you will be charged $100. Please note that your insurance company will not pay for late cancellations or "no show" appointments. This cancellation policy is standard in the mental health fields and will be strictly enforced. There will never be exceptions to this.

The credit card on file will be charged at the time of no show or late cancel. In the event that the credit card is declined, all late cancel fees and no show fees must be paid before any future appointments can be scheduled.

If you will be late for an appointment, please notify the office ahead of time and if you are no later than 15 minutes your appointment time will be held for you. After 15 minutes you will be charged for a missed appointment. This will be considered a no show and you will be charged a no show charge of $100.

Also, due to licensing requirements I agree to be physically in New Jersey each session and to give my current physical address accurately at the beginning of each session. I agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.

In accordance with the American Telemedicine Association (ATA) I agree to have Telemental health services *sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed using the google speed test. Google 'speed test' and use the google version. These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.*

I understand that Telemental health services *appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one present in the room.*

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telemental health services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Comprehensive Psychological & Wellness Center, LLC at 609-693-4343.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Telemental health services Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemental health services via an online HIPAA compliant telemedicine platform with the clinician listed below:

_____ _____

Patient Name (print) Patient Signature

Date:

_____ _____

Patient Name (print) Patient Signature

Date:

_____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature

Date:

_____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature

Date:

(* Both biological parents must sign)

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