Patient Information and Informed Consent for Teletherapy Services

Teletherapy is the delivery of psychotherapeutic services using interactive audio and visual electronic systems and/or by the electronic transmission of information where the provider and the patient are not in the same physical location.

The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Potential Benefits:

Teletherapy provides convenience and increased accessibility to mental health care for patients who are unable to be treated face to face due to various reasons such as living in remote locations, temporary circumstances such as being away at college, an extended stay away from home, illness, or having a physical limitation hpreventing travel to our office.

Potential Risks:

As with any mental health procedure, there may be potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

- Information transmitted electronically may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision making by the therapist.
- The provider is not able to provide every type of mental health treatment using interactive electronic equipment.
- The provider may not be able to provide for or arrange for emergency care that I may require, in cases of connection failure.
- Delays in mental health evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although unlikely, security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face-to-face visit but not in a teletherapy session may result in errors in clinical judgment.

Alternatives to the use of teletherapy

- Face to face sessions in the mental health provider's office.
- Referral to another mental health provider.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to teletherapy.
- I understand that the videoconferencing technology used by the provider is encrypted to prevent unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of teletherapy during the course of my care at any time.
- I understand that all rules and regulations that apply to the practice of Psychology in the state of North Carolina also apply to teletherapy, since the provider is located in North Carolina.
- I understand that the provider will not record any of our teletherapy sessions without my written consent.
- I understand that the provider will not allow any other individual to listen to, view or record any of my teletherapy sessions without my written consent.

My Responsibilities

- I will not record any teletherapy sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for providing and configuring any of my electronic equipment used for teletherapy. I understand it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I have read and understand that all of the practice policies of Stephanie Nilsen, PhD apply to all teletherapy as well as all in-person visits.
- I understand that I must provide emergency contact information for one person and give consent for them to be contacted in case of medical or mental health emergencies prior to starting teletherapy treatment.
- I understand that Stephanie Nilsen is licensed only in the state of North Carolina and that I must be physically in North Carolina for teletherapy sessions.

Emergency Contact Information
Provide the contact information of two people your provider can contact in the case of medical or mental health emergencies.

Name:
Phone:
Email:

Name:
Phone:
Email:

Patient Consent for the Use of Teletherapy
I have read and understand the information provided regarding teletherapy. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I acknowledge that my participation in the teletherapy process is voluntary and may possibly increase the risk of disclosure of my medical data. I hereby give my informed consent for the use of teletherapy in my mental health care in the course of my treatment.

Consent to Teletherapy

Your signature below indicates that you have read this Agreement and agree to its terms.

Name:

Date: