**Kathy Galleher, Ph.D.**

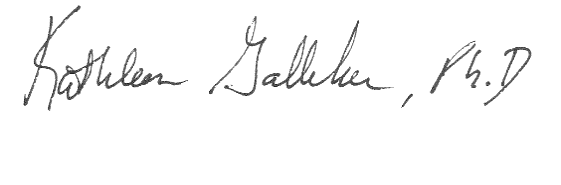
PO Box 601 Riverdale, MD 20738

Telephone: (301) 466-8501

**Kathy@KMGTherapy.com**

**INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES**

* There are potential benefits and risks of video- that differ from in-person sessions. We are able to maintain clinical support during times that it would not be possible to meet face to face. At the same time, it is different to meet online, and there can be a different feeling to it.
* Confidentiality still applies for telepsychology services, and nobody will record the session. You agree that you will not record sessions without prior discussion/agreement with me.
* I will be in a private space where no one can overhear the session. You agree that no one will be in the room with you or able to overhear the session, which includes family members.
* We agree to use a HIPAA compliant video-conferencing platform (such as Doxy.me, SecureVideo) for our virtual sessions.
* You agree to use a camera enabled device (like a webcam or smartphone camera) during the session to allow for video (if you are uncomfortable or unable, please talk to me about that before our session).
* You agree to be in a quiet, private space that is free of distractions during the session. Therefore public spaces, like coffee shops or outside in a park are not an appropriate place for a telehealth session.
* For the best security you should use a secure internet connection rather than public/free Wi-Fi.
* If you need to cancel or change your tele-appointment, the same 24 hour cancellation policy applies (except in cases of illness or technical disruptions that make connecting impossible.)
* We agree to have an alternate contact method (e.g., phone number where you can be reached at the time of the session) to continue the session or to reschedule it, in the event of technical problems interrupt our online session.
* We need a safety plan that includes at least one emergency contact and to be sure you are aware of the closest ER to your location, in the event of a crisis situation.
* Please confirm with your insurance company that the video sessions will be reimbursed and find out their preferred coding for telehealth.
* Ethically, I may only provide telehealth in circumstances where it is appropriate. If I determine that there are circumstances, such as risk of self harm or difficulty using the technology, that telepsychology is no longer appropriate, we will develop an alternative treatment plan.
* I have also received the Consent to Treatment/Office Policies document, and understand and agree to these conditions

Psychologist Name / Signature: 

Dr. Kathleen Galleher

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

**YOUR CONTACT INFORMATION**

Please give me two ways to contact you (ie. Cell phone and Email) where I can reach you if we have technical difficulties.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

If there were an emergency situation, and I needed to contact someone about your wellbeing, whom should I call? (name and phone number) . This must be a person who is local who could check in on you (i.e. resides with you or nearby.) If you don’t have such a person, we can discuss options.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, my closest Emergency Room Is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA**

1. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. explains HIPAA and its application to your personal health information in greater detail. **The law requires that I obtain your signature acknowledging that I have provided you with this information.**

Your signature below indicates that you have read this agreement and also serves as an acknowledgement that you have received the HIPAA notice form described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of client or authorized representative Date signed