CONSENT FORM

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CONSENT FOR TELEPSYCHOLOGY SERVICES

Name:_____ **Date of Birth:**_____

Address:_____

I agree and prefer to having psychological services with a registered psychologist through the means of electronic communications. Sessions will be provided through telephone, and/or videoconferencing. These services are provided through a secure provider and all sessions are LIVE with no prerecordings. Recordings of sessions are not permitted unless discussed and agreed upon by the client (client decision maker), prior to the scheduled session. In the event that telepsychology services are not suitable for the client's needs, in person sessions will be recommended for the client's consideration.

I agree to the following conditions:

1. All information that I reveal to the psychologist will be kept confidential except for those persons for whom I have given consent, unless one or more of the following situations occurs:

    - I present a danger to myself, other people, or their property.
    - I report child or elder abuse. I understand that in any of these situations, my psychologist will warn and/or protect anyone whom I might harm, and will if necessary, call the police, hospital, or child welfare.
    - My file is subpoenaed by law with or without my consent.
    - I fail to pay my bill. I agree that in this situation my psychologist may contact a collection agency with information about my identity and the services rendered to me.

2. I will pay in full for all psychological services for which I have accepted an appointment whether I keep that appointment or not, unless I give at least **24 hours** notice of cancellation. (Voicemail accepts messages 24 hours a day and email can be sent 24 hours a day.) Repeated missed appointments with insufficient notice could result in the termination of treatment.

3. If I am late for an appointment, I will pay in full for the appointment time, even though my session will not extend past the time for which it was booked. I agree that if I am more than 20 minutes late, the appointment may be cancelled, and I will have to pay the full fee for the appointment time.

4. This consent shall remain in effect for as long as I am being treated or assessed by my psychologist and will be considered terminated when a period of one year elapses since my last treatment or assessment session. If litigation or other legal issues are involved, I give permission for release of information to anyone or any organization indicated above until the legal matter in question is concluded.

5. **I understand that my confidentiality shall be protected by my psychologist after this agreement expires unless my information is subpoenaed.**

_____ _____

Signature of Client Date

_____ _____

Signature of Registered Psychologist Date