CHAGRIN COUNSELING ASSOCIATES

29525 Chagrin Blvd., #313
Pepper Pike, Ohio 44122

20525 Center Ridge Rd., #365
Rocky River, Ohio 44116

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Telepsychology Consent Form

1. I acknowledge that I am an Ohio resident, at least 18 years old, or if the patient is under 18 years old, that I am an Ohio resident and the legal guardian of the patient and that I consent to be treated or have my child/ward treated by one of the professionals at Chagrin Counseling Associates.

2. Chagrin Counseling Associates referred to throughout this document as "the practice", provides the ability for Ohio residents to attend live video-psychotherapy sessions. The platform currently used is SecureVideo (securevideo.com).

3. As a patient I acknowledge that there may be limitations to telepsychology and that some mental health concerns are not best treated by telepsychology. All patients will be assessed to determine if their concerns are appropriate for telepsychology services. Individuals who present with concerns that are not appropriately served by telepsychology services will not be treated using distance counseling/ telepsychology services and will be provided with alternative, in-person local service options whenever possible.

4. As a patient I acknowledge that if I am currently experiencing a severe mental health or physical health crisis during a telepsychology session, I will immediately call 911. As a patient I acknowledge that if I express intentions of immediate harm to myself and/or others and then disconnect services, the practice will call 911 and direct emergency personnel to my location.

5. As a patient I acknowledge that there may be a sudden and unexpected disruption of telepsychology services during a telepsychology session. If for any reason a session is interrupted (e.g., due to technical difficulties), the practice will make reasonable attempts to contact the patient through the other given means of contact.

6. The practice makes every effort to secure telepsychology sessions just as it does for in-person sessions. It complies with Ohio law and ethics to protect Protected Health Information for all patients. I acknowledge that despite all the safeguards being put into place, using telepsychology may pose a risk of confidential information being exposed. As a patient I acknowledge that by transmitting information over the Internet I understand that there is a risk that personal information may be compromised.

7. Phone Contact: As a patient and therapist we may occasionally communicate by cellular phone or text message. The practice uses Verizon Wireless service on an Apple iPhone. As a patient I acknowledge that this medium of communication may not be secure and may pose some risk of intentional or unintentional access by a third party. The Verizon privacy policy summary can be found at the following address: http://www.verizon.com/about/node/776023%26gt%3B%3B Apple's privacy policy can be found at the following address: https://www.apple.com/privacy/privacy-policy/

8. As a patient I acknowledge that I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

9. As a patient I acknowledge that it is my responsibility to maintain privacy on my end of the communication. Insurance companies, people and entities authorized by the patient, and those permitted by law may also have access to records and communications.

10. As a patient I acknowledge that the laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

11. As a patient I acknowledge that the practice provided me with a HIPAA privacy authorization form and that I have read and understand my Member Rights and Responsibilities.

Note: Your signature is an acknowledgement of understanding about the information detailed on this form.

_____ _____

Printed Name of Patient

Printed name of Legal Guardian of Patient (if applicable)

_____ _____

Signature of Patient or Legal Guardian

Date

_____

Email address for video psychotherapy sessions

_____

Cellular Phone for verbal contact or text messages