INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

PSYCHIATRIC CONSULTANTS & THERAPISTS, SC
229 E. Wisconsin Ave, Suite 600, Milwaukee, WI 53202 414-224-3737

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions
- Confidentiality still applies for telepsychology/telemedicine services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and your provider will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify your provider in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology/telemedicine sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for payment.
- As your provider, I may determine due to certain circumstances, if telepsychology/telemedicine is no longer appropriate and that we should resume our sessions in-person.
- Consent to send/receive SMS invitations from the provider including appointment or task reminders, and is aware of the possibility that data and messaging rates may apply.
- Patient is aware of opt-out instructions and support if needed:
  - Reply “STOP” to opt out   - Reply “HELP” for help.
- Please continue to comply with PCT Rules and Policies.
- ANY late cancels or reschedules will still require 24 hours notice call in advance or a Fee can be charged for the appointment.

Signature of Patient/Patient’s Legal Representative: ______________________________

Therapist/Psychiatrist/NP Name / Signature: ______________________________

Print Patient Name: ______________________________ **Date:** ________________