

# Informed Consent Addendum for Telehealth/telemedicine Services



**Harte**  
Behavioral  
Health

***These policies supplement the Provider-Patient Services Agreement, which you have already signed.***

**a** 95 Washington Street  
Suite 588, Canton, MA 02021  
**p** 781-713-4001  
**f** 781-713-4038  
**w** [www.hartehealth.org](http://www.hartehealth.org)

- 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 services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist 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 the psychologist 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 emergency room 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 sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

**By signing below, I acknowledge that I have reviewed this Telehealth Policy and I agree to these terms.**

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Provider Name (print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date