Associated Psychological Services, LLC.

Holmdel Executive Plaza APSwellness.com
717 N. Beers Street, Suite 2B Holmdel, NJ 07733 P: 732-264-2440 F: 732-888-7767

Teletherapy Informed Consent Form

Please Print and Complete Form BEFORE Appointment

Name: _____ Date of Birth: _____

Telecommunication: "Teletherapy" is the use of electronic transmissions to treat the needs of a patient. We offer video and audio forms of communication via the Internet through HIPPA compliant video conferences. This is designed to supplement your in person sessions with your therapist.

The laws that protect the confidentiality of medical information also apply to Teletherapy. The information you choose to share will be held in the strictest confidence. However, there are both mandatory and permissive exceptions to confidentiality, which are outlined in the detail in the Clients Rights and Responsibilities consent form.

You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment.

You understand that our Teletherapy occurs in the state of New Jersey, and is governed by the laws of this state.

You understand that Teletherapy is neither a substitute nor the same as face-to-face counseling/psychotherapy treatment.

You are responsible for the information security on your computer. The risks involved with telehealth include the potential release of private information due to the complexities and abnormalities involved with the Internet, such as viruses and other intrusions. Furthermore, there is the risk of being overheard by anyone near you, if you do not place yourself in a private and secure place.

You will need to participate in creating an appropriate space for your teletherapy sessions. Locate a secure, quiet, room where no one else can hear your conversations, to ensure confidentiality.

Please do not record video or audio sessions without your provider's consent. Making recordings can quickly and easily compromise your privacy.

It is your responsibility to contact your insurance carrier to confirm if your specific plan covers these services, that you should inform your therapist. You are fully responsible for all costs involved if your plan does not cover these services or leaves you with copays or coinsurance.

By signing this form, you are consenting to engage and participate in teletherapy services with your therapist. You understand that teletherapy includes audio and video communications, consultations, treatment, emails, telephone conversations.

I have read, understand, and agree with the information provided above.

_____ _____

Client (or Parent/Guardian's) Signature Date

_____

Printed Name

_____

Email address for Teletherapy: