Susan Bieber, Ph.D.
427 New Karner Rd.
Albany, N.Y. 12205
518-377-4093

Informed Consent for Telehealth Psychological Services

Prior to starting video-conferencing telehealth psychological services (hereafter "telehealth") I agree to the following:

There are potential benefits and risks of telehealth that differ from in-person psychotherapy sessions. Possible risks include but are not limited to technical difficulties, online security risks, and miscommunication/misunderstanding due to the nature of technology.

Confidentiality still applies for telehealth, and nobody will record the session without the written permission from the other person(s).

We agree to use a secure, HIPAA compliant video-conferencing platform for our telehealth sessions.

You, the patient, must be physically located in New York State to participate in telehealth sessions.

You need to use a personal webcam or smartphone for the telehealth sessions. Do not use equipment that belongs to your employer.

It is important to be in a quiet private space that is free of distractions (including TV, cell phone or other devices).

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 telehealth appointment, you must notify your provider as soon as possible. Call 518-377-4093. The same in office 24 hour cancellation policy applies to telehealth sessions.

You are responsible for payment at the end of each session. New sessions will not be scheduled if payment is not received.

To prepare for possible technical problems, we need a backup plan to restart the session or to reschedule it (e.g. phone number where you can be reached). Your provider will call you at this number if the session gets disconnected.

Callback Phone Number _____

We need a safety plan that includes at least one emergency contact and the closest Emergency Department to your location, in the event of a crisis situation.

Emergency Contact name and phone number _____
Name of your local hospital Emergency Dept. _____

Please confirm with your insurance company that telehealth sessions will be reimbursed. If they are not you are responsible for full payment.

You may decline telehealth at any time without jeopardizing access to future care, services, or benefits.

You have a right to ask any questions you have about your care or telehealth at any time during the course of your treatment. Please bring up any questions or concerns so we can discuss and address them.

Your signature below indicates that you understand the potential risks and benefits of telehealth and give voluntary infomed consent to participate in this treatment.

Patient Name _____
Signature of Patient or Legal Representative _____