SUSAN E. SCHWARTZ
Ph.D.

Informed Consent for Treatment using Telehealth Services

I, _____, agree to participate in telehealth services with Susan E. Schwartz PhD. This means that all my sessions will be provided electronically, not face to face.

I am aware that:

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 telethealth services, and nobody will record the session without the permission from the other person(s).

I agree to use the video-conferencing platform selected for my virtual sessions, and its use will be explained to me. The platform used by Dr. Schwartz is a HIPAA-compliant ZOOM program that is end-to-end encrypted.

I 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 I need to cancel or change my tele-appointment, I must notify Dr. Schwartz 24 hours in advance. In case of no-show, same rules apply as the face-to-face sessions.

We will have a back-up plan (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems.

And a safety plan will be set in place that includes at least one emergency contact and the closest emergency room to my location, in the event of a crisis situation.

I understand that at any time, I may decide to discontinue telehealth sessions with my provider. Dr. Schwartz will refer me to a local mental health provider who can provide face-to-face services.

Susan E. Schwartz, Ph.D.
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Here are the names and phone numbers of my local emergency contacts:

Next of kin_____

Primary care physician_____

Hospital Emergency Room_____

NAME: _____ SIGNATURE: _____ TODAYS DATE: _____

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