Joy Piccolino, PsyD
Licensed Psychologist

Telehealth Services Informed Consent Form

I ______________________________ consent to engaging in telehealth with Joy Piccolino, PsyD, LP. Telehealth will occur primarily through Doxy.me, a HIPAA-compliant telehealth platform, and less often via telephone. I agree to originate my appointment from a non-public location that allows privacy and minimizes the ability of the appointment being overheard.

I understand I have the following rights with respect to telehealth sessions:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information, as outlined in the Client Services Agreement, also apply to telehealth.

3. I understand there are risks to telehealth including but not limited to the possibility, despite reasonable efforts on the part of Joy Piccolino, PsyD, LP, that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

4. In addition, I understand that telehealth-based services and care may not be as complete as in-person services.

5. By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis, I should immediately call 911, a local county crisis agency or the National Suicide Hotline at 988, or go to the nearest hospital or crisis facility.

Records

The telehealth sessions shall not be recorded in any way by either participant unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature:____ Date:________________________