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*I/We \_\_\_\_\_ understand that in agreeing to engage in telepsychology (telehealth therapy), I/We are agreeing to the following statements:*

- 1. There are potential benefits and risks (which include, but are not limited to: breaches of confidentiality; theft of personal information; disruption of service due to technical difficulties) that differ from in-person sessions; while the platform called Doxy.me (which I recommend that we use) is encrypted and HIPAA-compliant, that is not true for phone calls, zoom calls, or face time calls (the use of which has been authorized by some insurance companies for the duration of the COVID-19 pandemic).*
- 2. Confidentiality still applies for telepsychology services, and nobody will record the session(s) without written permission from the other person(s).*
- 3. The client will use a secure internet connection rather than public/free Wi-Fi.*
- 4. The client will provide the therapist with a number at which she/he/they can be reached to restart or reschedule the session in the event of technical problems.*
- 5. The client will provide the therapist with at least one emergency contact (and with the name of the closest emergency room) to be used in the event of a crisis situation.*
- 6. The client will confirm with his/her/their insurance company that the telepsychology sessions will be reimbursed; if they are not reimbursed, the client is responsible for full payment.*
- 7. The therapist and client will regularly reassess the appropriateness of continuing to use telepsychology; either the client or the therapist may determine at any time, that telepsychology is no longer appropriate; at that point they would stop using it, and make a decision to resume sessions in-person or to end therapy.*
- 8. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services; this document does not replace other agreements, contracts, or documentation of informed consent.*

\_\_\_\_\_  
*Client Printed Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Patricia M. Conway, PsyD  
Licensed Clinical Psychologist*