MELISSA
GREENE
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## Teletherapy Informed Consent

**Patient Name:** ________________________________________

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.

(2) Teletherapy occurs in the state of NY (USA) ,and is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist in their NY office, where we meet to do our work.

(3) The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I should call 911 or proceed to the nearest hospital emergency room for help. I also authorize Dr. Greene to contact my emergency contact person if clinically necessary. A more detailed emergency plan will be discussed and created if necessary.

(5) In the event our teletherapy is not in my best interests, Dr. Greene will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy that differ from in-person sessions, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for using a secure internet connection, and being in a quiet, private space during the time of the session. I am also responsible for information security on my computer or smart phone.

(7) I understand that my insurance carrier may not provide coverage for out-of-network teletherapy services. I should verify coverage with my carrier if I have any questions about this.

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

______________________________________ ______________________________

**Patient Signature** **Date**