Informed Consent

**Definition of Service**

Telepsychology is a form of psychological service provided via internet technology, which can include the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data using interactive audio, video or data communications. I understand that telepsychology involves the communication of my medical/mental health information, both orally and/or visually.

**Client’s Rights, Risks and Responsibilities**

I understand that I have the following rights with respect to telepsychology:

1. I, the client, need to be and am a resident of Michigan or Virginia to receive telepsychology services with True Freedom Consulting, LLC.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. I understand that the laws that protect confidentiality of my personal information also apply to telepsychology. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are mandatory exceptions to confidentiality, including, but not limited to, reporting child, elder and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telepsychology interaction to other entities shall not occur without my written consent.
4. I understand that there are risks and consequences from telepsychology, including but not limited to, the possibility, despite reasonable efforts made by Dr. Carnigee Truesdale, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. True Freedom Consulting, LLC utilizes HIPPA compliant, secure, encrypted audio/video transmission software to deliver and store telepsychology services.
5. I understand that if Dr. Truesdale believes I would be better served by another form of intervention such as face-to-face services; I will be referred to a mental health professional that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of Dr. Truesdale, my condition may not improve, and in some cases may even get worse.
6. I understand the alternatives to psychotherapy through telepsychology as they have been explained to me, and in choosing to participate in telepsychology, I am agreeing to participate using video conferencing technology. I also understand that at my requestor at the direction of Dr. Truesdale, I may be directed to “face-to-face” psychotherapy.
7. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management form the use of telepsychology in my care, but that no results can be guaranteed or assured.
8. I understand and accept that telepsychology does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed tot eh nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for telepsychology services. If this is the case or becomes the case in the future, my psychologist will recommend more appropriate services.
9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telepsychology. I am responsible for (1) providing the necessary device (smartphone, computer or laptop with audio and webcam) and internet access for my telepsychology sessions, and (2) arranging a location with sufficient lighting and privacy that is free form distractions or intrusions for my telepsychology session. It is the responsibility of Dr. Truesdale to do the same on her end.
10. I understand and agree to wear appropriate attire and not engage in any consumption of alcohol or illicit substances during my telepsychology sessions.
11. I understand the need to be on time for sessions and if I need to reschedule my session to do so within 24 hours of my scheduled appointment or I will be charged $25.00. Payment for telepsychology services is due at the time of service and must be paid by credit/debit card. I will confirm with my insurance company that telepsychology sessions will be reimbursed; of they are not reimbursed, I am responsible for full payment of services.
12. I understand that Dr. Truesdale will be working with my minor child and as their parent or legal guardian I have read the above and give consent for my child to participate in telepsychology services with Dr. Truesdale.
13. I have read and understand the information provided above regarding telepsychology services, have discussed it with Dr. Truesdale and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telepsychology services and have had my questions regarding the procedures explained. I hereby give my informed consent/assent (if minor) to participate in the use of telepsychology services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

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Print Name Signature

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Parent/Guardian Signature Date