Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

TELEHEALTH CONSENT FORM FOR ANCHOR PSYCHOLOGY, INC

Informed Consent for Anchor Psychology
The following information is provided to clients who are seeking Anchor Psychology services. This document covers your rights, risks and benefits associated with receiving services, our policies, and your authorization. Please read this document carefully, and sign.

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Tele Mental Health Services Defined:
Tele Mental Health Services means the remote delivering of health care services via technology assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

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Limitations of Tele Mental Health Therapy Services:
While Tele Mental Health Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office. Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the behavioral health provider, I will take every precaution to insure technologically secure and environmentally private sessions.

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Interactive Video, Medical Records, Secure Email for Documents:
Your record will be maintained by Anchor Psychology according to regulations for mental health records.

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Cancellation Policy:
If you are unable to keep either a face-to-face appointment or a Tele Mental Health appointment, we request that you notify the therapist at least 24 hours in advance.

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I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

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I understand that there will be no video or audio recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

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Consent for Tele Mental Health Services Treatment:

I voluntarily agree to receive online therapy services for psychotherapy or other related services by Anchor Psychology to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Anchor Psychology at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunities have been offered to me to ask questions and seek clarification of anything unclear to me.

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Date: _____

Patient Name: _____

DOB: _____/_____/_____

_____

Patient/ Client Signature

_____

Parent/Guardian/ Legal Representative Signature (if minor or needed otherwise)

_____ _____

Clinician Signature Date