Informed Consent for Video Therapy Session

Client Name:_____

Thank you for choosing Viewpoint Psychological Services, PLLC. Please read the following video therapy consent and sign below indicating that you agree to the terms. If you have any questions, please let your therapist know and any concerns or questions will be addressed.

1. I understand that I am about to engage in video therapy sessions with my provider. I understand that the video conferencing technology will not be the same as an in-person session with a provider by its very nature, as we will not be in the same room. I also agree to be in a quiet place with limited interruptions with a good internet connection during the video therapy session. I will be available at the onset of the scheduled therapy session so that the session may occur on time.

2. I understand that the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the video therapy session if it is felt that the connections are not adequate for the situation.

3. My provider agrees to inform me and obtain my consent if another person is present during the session, for any reason. I also agree to inform my provider if there is another person present during the session. Other parties present are not considered clients and therefore do not have the same rights to confidentiality.

4. Sessions will not be recorded without specific permission from both parties. Neither the therapist, nor I will record any part of any session (including screen shots) without permission.

5. I understand that there are alternatives to a video therapy session available, including the option of finding another provider to see in-person if available in my area.

6. Financial arrangements will be made prior to the beginning of the session with Viewpoint staff in order for the payment of any copays or outstanding fees. Viewpoint staff will attempt to gain approval from my insurance company, if desired, yet cannot assure the client of insurance coverage until payment is made. All financial responsibility for the sessions will ultimately be up to me if insurance coverage for video sessions is denied, for any reason.

7. I understand that I can direct questions about video therapy session at any time to my provider or to the staff and/or owners of Viewpoint Psychological Services, PLLC.

8. I understand that this consent will last for the duration of the relationship with my provider, including any additional video therapy sessions I may have; I can withdraw my consent for video therapy sessions at any time and my provider will work with me to find a suitable alternative.

9. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a video therapy session as they would an in-person session. Other parties present are not considered clients and therefore do not have the same rights to confidentiality.

10. I agree to work with my provider to develop a safety plan, including identifying one or two emergency contacts that my provider has permission to contact, in the event of a crisis situation during our sessions.

    Emergency Contact #1_____

    Emergency Contact #2_____

11. I understand that my provider may decide to terminate video therapy services, if they deem it inappropriate or ineffective for me to continue therapy through video sessions. If so, my provider will work with me to develop an alternate plan.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of video therapy sessions.
- That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to participate in video therapy sessions with a provider from Viewpoint Psychological Services, PLLC.

Client Name (Printed): _____ Client DOB:_____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Viewpoint Provider:_____

Viewpoint Provider Signature/Date:_____