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ELECTRONIC SERVICE DELIVERY INFORMED CONSENT

Electronic Service Delivery is defined as "mental health therapy in any form offered primarily by electronic or technology assisted approaches when the psychologist and the client are not located in the same place during delivery of services." While working with me you will always have the opportunity to ask any questions that you have about therapy, electronic communications in general, and other issues involving my therapy with you. I will also assess your general knowledge of computers and the internet so that we may work in this way.

As a client receiving mental health services through electronic service delivery methods, you should understand:

1. This service is provided by technology including but not limited to video, phone, and text. I do not use email for therapy. It may or may not involve direct, face to face communication, There are benefits and limitations to this service. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Any paperwork involved will be exchanged by email or postal delivery. I will assess whether or not electronic therapy is appropriate for addressing your issues.

2. As a psychologist licensed in Ohio, I may only deliver services to residents or people located in Ohio. If you plan on leaving Ohio, please let me know so we can make arrangements for future work or referrals, as appropriate.

3. If a need for direct, face to face services arises, it is your responsibility to contact providers in your area if you are far from my office, or contact me.

4. You may decline any electronic services at any time without jeopardizing your access to future care. However, due to the Covid 19 health emergency, I will only be working from home at this time.

5. There are risks in transmitting information over the phone, internet, or email. These risks include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of services due to technical difficulties. You agree to accept these risks involved with the unencrypted exchange of information. The audiovisual program I use is called Doxy.me and is HIPAA compliant and confidential. Our sessions are not saved and are deleted by the program immediately after we are finished.

6. I will need to verify your identity at our first meeting and in subsequent sessions. You should be aware that misunderstandings are possible with phone, email, and internet chat, since nonverbal cues are relatively lacking. Even with audiovisual programs, misunderstandings may occur, since bandwidth may be limited and images may lack detail. I am an observer of human behavior. I gather information from your body language, vocal inflection, eye contact, and other nonverbal cues. Cultural differences and how they affect nonverbal cues may also be involved. I will assess whether this type of therapy is appropriate for your cultural experiences, your specific therapeutic issues, and your environment. Please let me know if you have any type of audiovisual impairment or cognitive impairment prior to beginning therapy. If you have never engaged in online therapy, you will need to have patience with the process and request clarification if you believe you are not being understood by me or if you don't understand something I say.

7. In an emergency that requires direct face to face contact, call 911 or go to the nearest emergency room. If the emergency can be managed by me over the phone or audiovisually, you can call me. But if I don't respond within a short period of time, please call 911, go to the emergency room, call the National Suicide Prevention Hotline at 800-273-8255, or the local Crisis Care at 937-224-4646.

8. If our service is disrupted, try to regain contact using the same medium. I will call you or text you to continue our session. If we are unable to establish contact, we can reschedule the rest of the session for another time.

9. Another risk of online therapy is to confidentiality. For example, if you use a public computer, consider the visibility of your screen and being overheard. It is recommended that you be in a private setting where other family members cannot overhear. Never use a work computer for therapy as your employer may have access. Be careful when using a shared network with others. You are responsible for confidentiality in your own environment.

10. If I need to contact you, I will use phone or text. In case of emergency or if I have concerns for your welfare, I may contact your emergency contact. If I need to send a bill, I will send it to your home address. If you do not want any of these forms of contact, please let me know.

11. It appears that most Ohio insurance companies are reimbursing for telehealth sessions. However, you should check with your insurance company. If insurance does not cover reimbursement , you agree to pay for the service. You should send your check on the day of your appointment to my mailing address, 206 Nicole Ct, Dayton, Oh 45420.

12. You should take precautions to ensure that your communications are directed only to me by checking the phone, fax number, email address or delivery address are correct. Don't leave a message unless the voicemail greeting identifies me.

13. Your communications with me will be kept in a locked file. I will write notes of our session which will be locked and accessible only by me. I will not record sessions and ask that you not record them either.

14. The laws, ethics, and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want my licensing information or other information regarding psychologists, you can find it at www.psychology.ohio.gov.

ACKNOWLEDGEMENT OF INFORMED CONSENT TO TREATMENT VIA ELECTRONIC SERVICE DELIVERY MEANS

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize Dr. Patricia Hayes to provide such treatment as are considered necessary and advisable via electronic service delivery.

By signing this Electronic Service Delivery Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

You also acknowledge that you have received a copy of the regular Informed Consent and the Notice of Privacy Practices for Dr. Hayes' practice.

Name_____

Signature_____

Date_____