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Telehealth Consent

All of my sessions take place by telehealth. This form explains what that involves, and sets up a plan in case of an emergency during a session.

HOW TELEHEALTH WORKS

- Sessions are held by secure video (Doxy.me or Zoom) or by telephone. For video sessions, you will receive a private link.
- I practice from Pittsburgh, Pennsylvania. I do not live in or offer in-person sessions in other states; I see patients located in PSYPACT states through telehealth under my Authority to Practice Interjurisdictional Telepsychology (APIT).
- Telehealth has the same confidentiality protections as in-person treatment, and the same limits (see the Informed Consent & Practice Policies).

BENEFITS AND RISKS

Telehealth allows continuity of care wherever you are and without travel. It also carries some risks: technology can fail mid-session; some nonverbal cues are harder to perceive, especially by telephone; and no electronic or phone connection is perfectly secure. Your privacy also depends on your setting. If at any point telehealth no longer seems right for you, we will discuss it, and I can help with a referral for in-person care.

YOUR PART

- Join from a private, quiet place where you will not be overheard or interrupted. Headphones help.
- Do not attend sessions while driving or doing anything else that requires your attention.
- Use a secure, password-protected internet connection, not public Wi-Fi when possible.
- Neither of us will record sessions, in audio or video, without the other's written consent.

EMERGENCY PLAN

Because we are not in the same room, I need to know how to get help to you if needed. This information is used only in an emergency.

Address where you usually attend sessions

City, State

Emergency contact name

Relationship

Phone

Nearest emergency room or hospital

Its city, state

May I contact your emergency contact if I believe you are in danger? ◯ Yes ◯ No

CONSENT

Initials

I have read this form, understand the benefits and risks of telehealth, and agree to the responsibilities described above.

Initials

I consent to receive psychological services by telehealth from Christopher McCann, PhD

Patient signature (typed full name serves as signature)

Date

Printed name

Date of birth