Dr. Jorge J. Asturias, PsyD, Inc.
A Professional Psychology Corporation

Informed Consent to Participate in Tele-health Services and Treatment

I____(undersigned client or designated adult*) give my consent to **Dr. Jorge J. Asturias** ("Treatment Provider") to perform tele-healthcare services (aka, video-conferencing, tele-psychology, tele-medicine).

The undersigned understands that the client has the following rights:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for tele-psychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in tele-psychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

- As your psychologist, I may determine that due to certain circumstances, tele-psychology is no longer appropriate and that we should resume our sessions in-person.

Patient Name____**Date of Birth**______________

Parent's Name of Minor____

Back up Telephone Number:____

Emergency Contact Name:____

Telephone Number:____

____   ______________________

Signature of Client or Authorized Parent/Guardian/Adult   Date