James E. Myers, Psy.D.
Clinical Psychologist

Addendum: Informed Consent Agreement for TelePsychology

Client Name:

I, _____ agree to participate in videoconferenced treatment with Dr James Myers, a Licensed Clinical Psychologist("provider''). This means that I authorize information related to me and my mental health and health care to be electronically transmitted in the form of images and data through an interactive video connection to and from the above named provider.

I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network.

I understand that I will be informed of the identities of all parties present (if any) during the treatment and of their purpose for being in attendance.

Dr. Myers will explain how telepsychology is performed. He will also explain how telepsychology will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

In brief, I understand that Dr. Myers will not be physically in my presence. Instead, we will see and hear each other electronically. Some information Dr. Myers would ordinarily get in face-to-face consultation may not be available through telepsychology. I understand that such missing information could in some situations make it more difficult for Dr. Myers to understand my problems and to help me get better.

I understand that telepsycholgy is a new form of treatment in an area not yet fully validated by research, and that there are potential risks, possibly including some that are not yet recognized, Among the risks that are presently recognized are the possibility that the technology may fail before or during treatment, that the transmitted information in any form will be unclear or inadequate for proper use

in treatment and that the information will be intercepted by an unauthorized person or persons.

I authorize the release of any information relevant to the processing of insurance claims including but not limited to my name, Social Security number, birth date, and clinical information.

I understand that at any time, the treatment can be discontinued by me. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate will not affect my continued treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or it could fail completely.

I also understand that, by law, and regardless of what form of communication I use, Dr. Myers may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others or that will endanger myself or others.

Treatment alternatives have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that telepsychology treatment does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the treatments effectiveness.

I understand that treatment records will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my medical records and that copies of treatment records are available to me on my written request. I also understand, however, that if Dr. Myers, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he may rightfully decline to provide them. If such a request if made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

I understand that I am not entitled to royalties or to other forms of compensation for participation in telepsychology treatment.

I have Dr. Myers contact information including his website: his telephone number, business address, and mailing address.

I unconditionally release and discharge Dr. Myers from any liability in connection with my participation in remote treatment.

I have read this document and understand the benefits and risks. I have had the opportunity to ask any questions and have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in telepsychology videoconference treatment.

_____ _____ _____

Name Date Witness

The above release is given on behalf of _____ because the client is a minor or has been determined to be incompetent to give medical consent.

_____

Parent or Legal Guardian Date