

WILLIAMSBURG THERAPY GROUP

A Mental Health Collective

Informed Consent for Telepractice Services

As used in this form, “Telepractice therapy” means a psychologist’s provision of therapy services to me which are not in-person and which instead are provided using electronic methods of communications, which may include, without limitation, interactive video and audio communications between me and the psychologist over the internet or through wireless communications, cable, telephone or other electronic means.

By my signature below, I confirm that I understand the following:

1. Telepractice therapy is an alternative to in-person therapy. I have had the alternatives to Telepractice therapy explained to me and I am choosing to participate in Telepractice therapy.
2. Telepractice therapy provides convenient access to therapy in that it allows me to receive treatment from my psychologist without having to travel to my psychologist’s office.
3. There is a risk that Telepractice therapy may not, in certain cases, be as effective as in person therapy. For example, this risk could be increased by the fact that, with Telepractice therapy, my psychologist and I will not be sitting face to face and non-verbal communication, such as body signals, may not be as readily available to my psychologist and me as would be the case if treatment were provided in person.
4. There are no guarantees that Telepractice therapy will be effective in treating my mental health and/or behavioral health condition and/or improving my mental health or behavioral health condition.
5. There are risks when using electronic communications. It is possible that my personal information could be disrupted, interrupted, or accessed by unauthorized persons as a result of events beyond the reasonable control of my psychologist, including but not limited to natural disasters, electronic failures or improper or negligent acts or omissions of third parties.
6. I understand that I am responsible for (a) providing the necessary computer or device, telecommunications equipment and internet access for Telepractice therapy (b) the information security on my computer or device and (c) arranging a location with sufficient lighting that is free from distractions and intrusions and has sufficient privacy in order to protect the confidentiality of my personal health information.
7. During the course of my therapy, my psychologist may decide that Telepractice therapy is not appropriate for



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- me. My psychologist may ask to me visit the office for an in-person assessment in order to make this decision. If at any point my psychologist believes that Telepractice therapy is no longer appropriate for me, my psychologist can ask me to participate in in-person therapy instead and thereafter can cease providing me with Telepractice therapy.
8. I have the right to withdraw my consent to the use of Telepractice therapy in the course of my therapy at any time.
 9. I agree that certain situations, including emergencies and crises, are inappropriate for Telepractice therapy. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
 10. **Appointments.** I understand that once I begin treatment with Williamsburg Therapy Group, I will have a specific time reserved to meet with my psychologist, typically once a week for 45/40 minutes. I am responsible for attending my session via Telepractice therapy on time and understand that if I appear late for a session it unfortunately means that I will lose time from that session. In addition, if there are excessive absences in my assigned appointment slot, my psychologist reserves the right to offer that appointment slot to another client.
 11. **Fee.** I understand that Williamsburg Therapy Group and I have agreed on a starting fee for treatment, as indicated in the appointment information. I also understand that Williamsburg Therapy Group has the right to increase my session fee at any time by giving me verbal and/or written notice at least 4 weeks in advance of the fee increase.
 12. **Payment.** I understand that payment is due in full at the end of each session. If I fail to pay for 2 or more consecutive sessions, Williamsburg Therapy Group has the right to stop treatment with me and refer me. I will pay by cash, check or credit card (MasterCard, Amex or Visa).
 13. **Cancellation Policy.** I understand that if I do not give Williamsburg Therapy Group at least 48 hours advanced notice of cancellation of any scheduled session, I will be charged for a full session. If I have to cancel a session, I agree to notify my psychologist at Williamsburg therapy Group at least 48 hours in advance via email at contact@williamsburgtherapygroup.com in order to avoid incurring the charge of my session fee.
 14. **Notice of Privacy Practices.** I acknowledge that I have had the opportunity to receive a copy of Williamsburg



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Therapy Group's Notice of Privacy Practices. I understand that the practices outlined in this document (as updated from time-to-time) will be followed concerning my confidential information.

I have read and understand the information provided above regarding Telepractice therapy, have discussed it with my psychologist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to the provision of Telepractice therapy to me by Williamsburg Therapy Group.



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