ANDREA CRONIN
PSYCHIATRIC NURSE PRACTITIONER

INFORMED CONSENT FOR ONLINE THERAPY VIA DOXY.ME

This form is designed to allow you to give informed consent for the use of video technology for online visits for medical management. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting telemental health services.

Online telemental health is defined as the use of technology to have a visit for medical management. We will use Doxy.me, a HIPAA compliant platform that uses video and audio technology through a webcam on your device (a phone, laptop, desktop, or tablet), and my device to connect us securely.

All data shared outside of our video session on Doxy.me is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of telemental health include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, telemental health allows for greater accessibility to services for clients with limited mobility or lack of transportation.

With all technology, there are some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the provider. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session can not be completed via online video, the provider will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here:

Main Number: _____ Alternate Number: _____

If for any reason, we are unable to connect and you are in immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I agree to take full responsibility for the security of any communications or treatment on my own computer and in my physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online visit and that all information disclosed within visits and the written records pertaining to those visits are confidential and may not revealed to anyone without written permission, except where disclosure is required by law, as previously consented.

I understand that I am not allowed to do any recordings, screenshots, etc. of any kind, of any visit, and are grounds for termination of the client-provider relationship.

Patient Signature: _____ Date:_____