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VSEE is the software technology used for this service

Phillips Mental Health Counseling. P.C Form # 12: Telepsychology Consent Form

Telepsychology is the delivery of psychological services using interactive audio or electronic audiovisual systems where the therapist and the client are not in the same physical location. The interactive electronic systems used in telepsychology incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These contracts include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. I use **VSEE** communications for this service, and it is encrypted end to end. I do have a Business Associates Agreement (BAA) with VSEE, to be in compliance with (HIPPA), *Health Insurance Portability and Accountability Act, of 1996*.

Potential benefits include increased accessibility to psychological care and convenience. However there are also potential disadvantages, including that technology can fail, causing a breach of privacy. Traditional face to face meetings are the alternative to the use of telepsychology, and you have the right to choose the means of services you would prefer.

I understand that the laws that protect the privacy and confidentiality of private health information also apply to telepsychology. I understand that the **VSEE technology** used by Lynda Phillips is encrypted to prevent unauthorized access to my personal health information. I have the right to withhold or withdraw my consent to the use of telepsychology during my care at any time. I understand that, in this event, Lynda Phillips will work with me to find an alternative form of care.

I understand that all rules and regulations which apply to the practice of clinical mental health therapy in the state of New York also apply to telepsychology.

My Responsibilities. I will not record any telepsychology sessions without written consent from Lynda Phillips. I understand that Lynda Phillips will not record any of our telepsychology sessions without my written consent. I will inform Lynda Phillips if any other person can hear or see any part of our session before the session begins. Lynda Phillips will tell me if any other person can hear or see any part of our session before the session begins. I understand that I, not Lynda Phillips, am responsible for the configuration of any electronic equipment used on my computer which is used for telepsychology. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the state of New York and that I must be physically present in the state of New York during my appointments with Lynda Phillips to be eligible for telepsychology services from Lynda Phillips.

Patient Consent to the Use of Telepsychology. I have read and understood the information provided above regarding telepsychology, I have discussed it with Lynda Phillips and all of my questions have been answered to my satisfaction. By signing below, I at this moment give my informed consent for the use of telepsychology in my care.

Signature of Patient: _____.

(or person authorized to sign for Patient)

Date: _____.