

# Deborah S. Zwick, Ph.D.

## Teletherapy Informed Consent Form

This Informed Consent for Electronic Psychotherapy contains important information concerning engaging in electronic psychotherapy or Teletherapy. Please read this carefully and let your therapist know if you have any questions. This consent shall only apply to patients and therapists physically within the State of Colorado seeking therapeutic treatment within the State of Colorado. This Informed Consent shall be signed in conjunction with Dr. Zwick's Disclosure Statement.

Teletherapy allows individuals who may not have local access to a mental health professional and/or specialized treatment to receive services via electronic means (e.g., telephone, email, HIPAA compliant face-to-face service via the Internet). Teletherapy may also be used when issues related to scheduling, transportation, child-care and/or mobility arise during the course of treatment.

This **Informed Consent** is between:

**Patient:** \_\_\_\_\_ and **Dr. Deborah S. Zwick**

**Dates of Face-to-Face In-Person Meeting(s):** \_\_\_\_\_

**Diagnosis and/or Treatment Plan:** \_\_\_\_\_

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**R e a s o n ( s )   T e l e t h e r a p y   i s   A p p r o p r i a t e   f o r   t h i s   P a t i e n t :**

\_\_\_\_\_

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### Benefits and Risks of Electronic Psychotherapy

Electronic psychotherapy, also known as Teletherapy, is different from traditional therapy in that the Patient and Therapist do not meet face-to-face in-person. One of the benefits of electronic psychotherapy is that the Patient and Therapist can continue therapeutic sessions without being in the same place. This can be convenient if either the patient or therapist is out of town or the patient or therapist is unable to attend a scheduled session in person.

Although there are benefits of electronic therapy, there are also risks involved. These risks include, but are not limited to: losing the ability to read physical cues, vocal cues/tones, and facial expressions; an inability to provide immediate emergency services/care; experiencing technical issues that disrupt the counseling session; a risk that the communications may be overheard if the Patient or Therapist does not conduct the session in a secure/confidential place; and there is a risk that the communications may be accessed by unknown third-parties regardless of the security measures in place.

I, the therapist, have received education, training, and experience, including specific training in electronic psychotherapy via workshops, in-services, and legal consultation.

### **Method of Electronic Psychotherapy**

Based upon the Patient’s needs and the therapist’s assessment of those needs, the following method of electronic psychotherapy has been chosen:

€ Telephone            € Video tele-medicine (Doxy.me)            € Other: \_\_\_\_\_

### **Security Measures**

Dr. Zwick uses the following security measures to ensure that the communications are secure:

- State-of-the-art, HIPAA- and HITECH-compliant encryption through zoom.us.
- Encrypted, password-protected computers & devices.
- Sessions conducted in a private location where others cannot hear me.

### **Confidentiality:**

Confidentiality still extends to any communications done through electronic psychotherapy. Although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not gain access to our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third-party.

In order to maintain confidentiality when engaging in electronic psychotherapy, it is important that all sessions be conducted in a confidential place. This means that you as the patient agree to participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. I cannot guarantee that the place you choose to conduct the session is confidential. Do not have sessions in public places such as internet cafes or libraries. I will ask you at the beginning of each electronic psychotherapy session whether you are in a safe, secure, and confidential place. If you say “yes”, I will assume that you are. I will not be able to read/understand any hidden meanings or messages if you only say “yes.”

In addition to asking whether you are in a confidential location, I will ask you to verify your identity in order to proceed. If our sessions cut-out and we reestablish a connection, I will ask you to verify your identity and location again.

The extent of confidentiality and the exceptions to confidentiality that I listed in my Disclosure Statement still apply in electronic psychotherapy. In general information disclosed to a mental health professional in the course of a professional psychotherapeutic relationship cannot be disclosed without the Patient’s consent. Exceptions to this general rule include:

- The disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S. §13-90-107
- I am required to report child abuse or neglect situations
- I am required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation

- If I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened, and may be required to take immediate action to protect you or others from harm
- If you become gravely disabled, I am required to report this to the appropriate authorities
- I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information

There may be additional exceptions to confidential communications that I will identify to you as the situations arise throughout our professional relationship.

**In-Person Sessions:**

From time to time, we will schedule in-person sessions to “check-in” with one another. If at any time while we are engaging in electronic psychotherapy, I determine, in my sole discretion, that electronic psychotherapy is no longer effective we will discuss options of returning to face-to-face in-person counseling.

**Emergencies and Technology:**

Unlike in traditional in-person psychotherapy where a therapist may be better able to evaluate the seriousness of a Patient’s threats to harm oneself or others based on a combination of physical, behavioral and verbal cues; assessing and evaluating threats and other emergencies is more difficult when conducting psychotherapy electronically.

As such, I will ask you where you are located at the beginning of each session so that if I am required to contact emergency personnel (police, hospital, fire), I can alert them of your location. We will not proceed with the session until emergency telephone numbers are located. This emergency plan is not to “track” you or keep “tabs” on you, but rather to ensure your safety.

If the session cuts out, meaning the technological connection fails, and you are having an emergency **do not call me back**, but call 911, the Colorado Crisis Hotline at 844-493-TALK (8255), or go to your nearest emergency room. *Call me after you have called or obtained emergency services.*

If the session cuts out and you are not having an emergency, hang up and I will wait two (2) minutes and then re-contact you via the electronic psychotherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes then call me on the phone number I provided you (970-376-1240).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

You may be required to have certain system requirements to access electronic psychotherapy via the method set forth above. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

In order to maintain confidentiality and security for your electronic devices, please review the security protocols for **doxy.me**. If you have any trouble locating this information please contact me and I will assist you in locating the appropriate contact information.

**Fees:**

The same fee rates shall apply for electronic psychotherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted using electronic psychotherapy. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session.

**Sexual Intimacy:**

In a professional relationship (such as psychotherapy), sexual intimacy between a therapist and a patient is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Psychologist Examiners or the State Board of Social Work Examiners.

**Records:**

The electronic psychotherapy sessions shall not be recorded in any way unless agreed to by mutual consent. I will maintain a record of our session in the same way I maintain our in-person sessions in accordance with my electronic record storage policy set forth in my Disclosure Statement.

**Informed Consent:**

I, \_\_\_\_\_, the patient, having been fully informed of the risks and benefits of electronic psychotherapy; the security measures in place, which include procedures for emergency situations; the fees associated with electronic psychotherapy; the technological requirements needed to engage in electronic psychotherapy; and all other information provided in this informed consent, agree to abide by and understand the procedures and policies set forth in this consent; and, voluntarily and not under duress or coercion consent to engage in electronic psychotherapy with Dr. Zwick. I understand that I may revoke this agreement at any time for any reason. Such revocation is not retroactive.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Zwick's signature

\_\_\_\_\_  
Date