

# Strides in Psychotherapy

(732) 873-5570

15 Clyde Road, Suite 102  
Somerset, NJ 08873

31 Dehart Place, Suite 2  
Morristown, NJ 07960

*Tammy Dorff, Psy.D. NJ Lic#3950*

*Linda Tamm, Psy.D NJ Lic #3926*

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## Telehealth Consent

I understand and agree to the following:

- There are potential benefits and risks of video conferencing (i.e., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologists will explain to the best of their ability how to use it.
- I need to use a computer with a webcam and microphone, and/or a smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important whenever possible to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify the psychologist in advance. The same cancellation policy applies for both in-person and telehealth sessions.
- I am aware of a back-up plan (e.g., phone number where you and I can be reached) to restart the session or to reschedule it, in the event of technical problems.
- I am aware of safety plans that include at least one emergency contact and the closest ER to my location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parents or legal guardians (and their contact information) for you to participate in telepsychology sessions.
- We will make every effort to confirm your insurance company's coverage for telehealth sessions and will let you know if there are any issues with this. If there is a financial hardship related to this coverage, please speak with us about your fees. As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person, when possible.

\_\_\_\_\_  
Patient Name

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

\_\_\_\_\_  
Parent/Guardian Name (if applicable)

\_\_\_\_\_  
Signature of Parent/Guardian (if applicable)

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date