**Leah A. McGuire, Ph.D.**

Pediatric Neuropsychologist

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**Telemedicine Informed Consent**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) hereby consent for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I to engage in telemedicine (e.g., internet- or telephone-based therapy) with Dr. Leah A. McGuire. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, parent intakes, parent feedbacks, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications between a psychologist and a patient who are not in the same physical location. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent for telemedicine at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my appointment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; when my psychologist suspects that I’m a risk to myself or others; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that Dr. McGuire uses interactive technologies that are compliant with local and federal laws (e.g., HIPAA) and incorporates network and software security protocols to protect the confidentiality of patient information transmitted via any electronic means. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Although Dr. McGuire has taken substantial steps to ensure the confidentiality and privacy of my telemedicine services, I understand that Dr. McGuire cannot guarantee the security and privacy of any internet or electronic transmissions or communications. **I agree to take full responsibility for the security and privacy of any communications or services on my end including on my own computer (or other electronic devices used in telemedicine services) and in my own physical location. My responsibility includes but is not limited to: (1) taking steps to prevent unintended persons in my environment from hearing content discussed; (2) refraining from forwarding my email/text communications with Dr. McGuire; (3) taking steps necessary so that unintended persons cannot see text messages, internet searches, or other private information on my phone/computer, (4) refraining from writing confidential information on social media sites; (5) and implementing my own privacy settings on social media sites.** I also understand that, should I disclose my personal information about my telemedicine sessions to others, Dr. McGuire and I have no way of controlling if that information remains confidential.

(4) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of Dr. McGuire, that: the transmission of my medical information could be disrupted or distorted by technical failures (e.g. disruption in internet connectivity; server maintenance; upgrades; or other problems such as software or hardware malfunction); the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons despite Dr. McGuire maintaining my records in accordance with state and federal laws; misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner (e.g., text messaging, emails); and/or overage charges on my data plans. I understand that any technical problems are outside of the control of Dr. McGuire, and Dr. McGuire makes no guarantee that such services will be available in my area.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of Dr. McGuire, my condition may not improve, and in some cases, may even get worse.

(5) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(6) I understand that use of a telephone is usually the most reliable back-up plan for technical problems with video-based telemedicine and that I’m expected to continue any disrupted video-based sessions via telephone (or another agreed-upon back-up means) at the sole discretion of Dr. McGuire. I understand that if I choose not to continue my session via any feasible back-up methods, I will still be charged the full rate for the session. However, if something occurs to prevent or disrupt the use of our back-up means for conducting the telemedicine session, a new appointment will be rescheduled. If technical disruptions last for more than five minutes, my session will be pro-rated.

(7) I understand that I have the right to access my medical information and copies of medical records in accordance with New Jersey law.

(8) I understand that telemedicine may be appropriate for me if I’m capable of taking care of myself and my environment. To best ensure my safety, I will participate with Dr. McGuire during the first appointment in developing a plan for managing any emergency situations including naming an emergency contact person.

I should not seek telemedicine services if I am experiencing a mental health crisis or having suicidal or homicidal thoughts or if I engage in life-threatening behaviors towards myself or others. If a life-threatening event should occur, I agree to immediately contact my medical doctor or psychiatrist, a crisis hotline, local law enforcement, 9-1-1, or have someone take me to the closest emergency room. If a crisis occurs during my telemedicine services, Dr. McGuire will contact my emergency contact, a crisis hotline, local law enforcement or medical services, and/or 9-1-1 even if I don’t provide verbal or written authorization for Dr. McGuire to do so.

Dr. McGuire will continue to evaluate my appropriateness for telemedicine services throughout treatment, and if it determines that I am not appropriate at any time, it will recommend in-person services with Dr. McGuire or another practice or agency.

(9) I understand that these services may not be covered by insurance and that, if there is intentional misrepresentation, therapy will be terminated. I also understand that it is my responsibility to confirm insurance coverage with my insurance company if I hope to receive reimbursement from my insurance company for these services. I understand that not all insurance companies cover telemedicine services.

(10) I understand that I am expected to truthfully disclose my location at the start of every telemedicine session for purposes of helping Dr. McGuire ensure my safety.

(11) All appointments will be scheduled according to Eastern Standard Time (EST).

(12) I understand that my psychologist will do his/her best to return my call, email, or other method of communication within twenty-four hours on business days.

(13) I understand that my psychologist may need to coordinate care with other providers working with me and that these communications will be done via telephone or other secure means.

(14) I understand that I am **not** allowed to video or audio record any telemedicine sessions without Dr. McGuire’s explicit consent for me to do so. If Dr. McGuire suspects or determines that I’m recording sessions without prior consent, services may be terminated, and I’ll be given referrals to continue my care.

(15) I understand that I will need access to and be familiar with the appropriate technology in order to participate in telemedicine services.

(16) I understand that, should I use a computer and/or other equipment owned by another person or agency, that any information I enter can be considered by the courts to belong to the owner of the computer and/or equipment and that my privacy may be compromised. I understand that using my own equipment to communicate is best for ensuring my privacy.

(17) This document does not replace other agreements, contracts, or documentation of informed consent that I’ve previously signed.

(18) I unconditionally release Dr. McGuire and her team from any liability in connection with my participation in telemedicine services.

**I have read this document carefully and fully understand the risks and benefits of telemedicine, which have also been explained to me verbally. I have discussed this with Dr. McGuire, and all of my questions have been answered to my satisfaction. I agree to abide by all terms above. With this knowledge, I voluntarily consent to me and/or my child participating in telemedicine services including, but not limited to, any care, treatment, and services deemed necessary and advisable under the terms described herein.**

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (if ≥ 14 years-old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have discussed the information contained on the front and back of this form with the patient and/or his/her parent(s)/guardian, and my observations indicate that informed and willing consent has been obtained.

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Dr. Leah A. McGuire, Ph.D. Date

Pediatric Neuropsychologist

N.Y. Licensed Psychologist #020693

N.J. Licensed Psychologist #5529

P.A. Licensed Psychologist #PS018073