

The Office Of:  
ELLEN DYE, Ph.D.

*Clinical Psychologist*  
6325 Executive Boulevard  
Rockville, MD 20852  
Telephone (301) 770-0275  
Fax (301) 770-0276

### INFORMED CONSENT FOR TELEHEALTH SERVICES

This Informed Consent for Telehealth Services contains important information about conducting psychotherapy using the phone or the Internet. If you have any questions, please feel free to discuss them with me.

#### Telehealth Procedures

Please log in to your email and click the Zoom link that I have sent you. You will need to activate the camera and microphone on your device or computer. If there is a connection problem, I will resend you the Zoom link or call you. Given the ongoing COVID situation, we are also able to use Facetime and Google Duo.

Our safety plan includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation. If you are not an adult, the permission and contact information of your parent or legal guardian is required for you to participate in teletherapy sessions.

#### Confidentiality

It is important to protect your confidentiality and/or your child's confidentiality. Please ensure that sessions take place in a quiet and private location where others will be unable to observe or listen.

My video conferencing system meets HIPAA standards of encryption and privacy protection. The nature of technology, however, poses risks that our communications may be compromised, unsecured, or accessed by others. Please take reasonable steps to ensure the security of our communications by using a secure network, updated encryption methods, and firewalls.

#### Informed Consent

By signing this agreement, you are stating that you are aware that I may contact the necessary authorities in case of a life-threatening emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider, at the nearest hospital, or by calling 911.

Please note that the Crisis Center phone number is 240-777-4000.

Physician/Psychiatrist Name: \_\_\_\_\_

Physician/Psychiatrist Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number(s): \_\_\_\_\_

Emergency Contact Email: \_\_\_\_\_

Your signature below indicates that you have read and understood this Telehealth Informed Consent Agreement.

Client Name: \_\_\_\_\_

Guardian or Parent name (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Date