Port Jefferson Psychological & Vocational, P.C.
Davis Professional Park
5225-46 Route 347
Port Jefferson Station, New York 11776
(631) 928-4635

Prior to telehealth services being rendered, this form must be completed and placed into the patient's medical record.

Provided information must be accurate, may be verified by the provider or another appointed designee through the organization, and will be utilized to ensure the safety of all parties. If the treating provider determines there is a justifiable reason to break confidentiality to ensure the safety of the patient or another person due to the patient's behavior, the provider is authorized to do so. Conditions for breaking confidentiality may include, but are not limited to: if the patient is determined to be an active harm to themselves or to another, if abuse is recognized, or for a medical or behavioral emergency. If confidentiality must be broken, the treating provider will make reasonable efforts to inform the patient/parents prior to or following the disclosure, as allowed.

General Contact Information:

Patient Name: _____

Legal Guardian Name: _____Relationship to Patient: _____

Patient Home Address: _____

Best Phone Number to Reach: _____

Emergency Contact Information:

Best Contact Person 1: _____Relationship to Patient _____

Best Phone Number to Reach: _____

Best Contact Person 2: _____Relationship to Patient _____

Best Phone Number to Reach: _____

Nearest Medical Center Name: _____

Nearest Medical Center Address: _____

Phone Number: _____

Nearest Police Department Name: _____

Nearest Police Department Address: _____

Phone Number: _____

TELEHEALTH REQUIREMENTS

- doxy.me is an online communication tool allowing for face-to-face video and it is HIPAA compliant. For more information about doxy.me security and privacy, please see: https://help.doxy.me/en/articles/95911-security-and-privacy-overview
- doxy.me requires the use of a browser but does not require any software download.
- Please be online at least five minutes prior to session, alone, in a quiet room, with the door closed.
- For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. Headphones add additional security and audio quality.
- Confidentiality should be treated like an in-office session: no outside distractions, turn off cell phones, close other programs on your computer, and be on time.
- I understand that my therapist may decide to terminate teletherapy services if they deem it inappropriate for me to continue treatment through video sessions. In this case, they may provide in-person care or make a referral to another provider or clinic, if necessary.

_____ _____

Signature of Patient/Responsible Party Date

TELEHEALTH CONCIDERATIONS

Potential benefits to using telepsychology include (but are not limited to)

- reduces potential exposure to illnesses
- more convenient and accessible for many
- cost effectiveness and savings (eg.travel expenses)
- can help patients maintain continuity of care due to convenience and ease

Potential risks to using telepsychology may include (but are not limited to)

- lack of reimbursement by your insurance company
- technology dropping out due to internet connections
- delays due to connections or other technology issues
- a breach of information that is beyond our control
- discomfort with virtual face to face vs. in person treatment
- difficulties interpreting non-verbal communication
- limited access to resources if risk of self-harm or harm to others becomes apparent

_____ _____

Signature of Patient/Responsible Party Date

LIMITS ON CONFIDENTIALITY

I also understand the following limitations of doxy.me video therapy sessions:

- Any internet-based communication is not 100% guaranteed to be secure/confidential. I agree that my therapist and Port Jefferson Psychological & Vocational, P.C. should not be held responsible if any outside party gains access to the video feed.
- In a crisis or emergency situation that needs immediate attention, (especially if there is the threat or intent of serious harm to myself or someone else), I will dial 911, or go to a mental health hospital/Emergency Room.
- Technical problems could occur. If the call is disrupted, I will call back within ten minutes. If reconnection cannot occur, the session will be rescheduled.

_____ _____

Signature of Patient/Responsible Party Date

OFFICE POLICY

- For all video sessions, anyone participating must be visible on the screen. For individual sessions, this is the patient only. For family/parent sessions, this is only those members who will be involved in the session.
- For sessions with a minor – anyone under 18 years of age - a parent/responsible adult must be available in your location.
- You are not permitted to record video sessions in any manner. doxy.me does not record these sessions either. They disappear once the session is over.
- For any missed sessions, the regular cancellation policy will apply.

_____ _____

Signature of Patient/Responsible Party Date

EMERGENCY PLAN

If there is no fear of harm to patient or another person, the patient/family is asked to write down information to be discussed at the next session. Should more immediate responses be required, the patient/family may call the office. Depending on the nature of the information, the provider may require either a brief phone meeting, or an additional session to manage situations.

If there appears to be a possibility of harm to the patient or to another person, the patient/family is to immediately go to the local medical center/emergency room listed on this form. They are asked to contact the provider after safety has been ensured. If the patient/family is closer to another medical center than what is listed, they are to go to that location. Following stabilization and discharge, the patient/family is to provide the provider with an indication of what led to the need for a hospital visit, details of the hospital stay (e.g., medications, diagnoses, treatment summary), and both emotional and behavioral status post-discharge.

_____ _____

Signature of Patient/Responsible Party Date

TELEHEALTH AGREEMENT

I have been informed of and understand the risks and procedures involved with using the videoconferencing technology. I agree to the terms listed above and I hereby voluntarily consent to the use of this platform for appointments. I agree that my therapist and Port Jefferson Psychological & Vocational, P.C. should not be held liable in the event that any outside party passes technology security and discovers personal or confidential information. This consent will last for the duration of the relationship. I can withdraw my consent for a video therapy session at any time.

Note: At any time, the provider can decide that telehealth services are no longer appropriate and as such, may be terminated. If such an event occurs, the provider will provide alternative referral options should face-to-face treatment not be possible.

_____ _____

Signature of Patient/Responsible Party Date