Mark R. Dell, Psy.D, L.L.C.
21 NJ-31, Suite A6A
Pennington, NJ 08534
(609) 439-6526

TELEHEALTH INFORMED CONSENT

Patient Name: _____ Date: _____

I. NATURE OF TELEHEALTH SERVICES

Telehealth involves the delivery of psychological services using interactive audio and video technology when the patient and provider are in different locations. Sessions are conducted using a HIPAA-compliant platform.

II. BENEFITS AND LIMITATIONS

Potential benefits include improved access to care and continuity of treatment. Limitations include the possibility of technology failure, reduced ability to observe nonverbal information, and the fact that telehealth is not appropriate for all clinical presentations or for emergency situations.

III. CONFIDENTIALITY AND SECURITY

The same confidentiality protections and legal limits described in the Notice of Privacy Practices apply to telehealth sessions. However, no electronic transmission can be guaranteed to be entirely secure. You are responsible for selecting a private location for sessions where you will not be overheard.

☐ I agree not to record sessions without written consent, and I understand the provider will not record sessions without my written consent.

IV. LOCATION AND LICENSURE

Psychological services are governed by the licensing laws of the state in which the patient is physically located at the time of service. This provider is licensed in New Jersey. You agree to be physically present in New Jersey during sessions unless other arrangements have been confirmed in advance and in writing.

Patient's usual location during telehealth sessions: _____

V. EMERGENCY PROTOCOL

Telehealth is not an emergency service. In the event of a mental health emergency, you should call 988 (Suicide & Crisis Lifeline) or 911, or proceed to the nearest emergency department.

Patient's physical address during sessions (required for emergency response):

_____

Local emergency contact name: _____ Phone: _____

VI. TECHNOLOGY FAILURE

If the connection is lost during a session, the provider will attempt to re-establish contact. If reconnection is not possible, the provider will contact you by telephone at the number below.

Telephone number for backup contact: _____

VII. FEES

Telehealth sessions are billed at the same rate as in-person sessions. The cancellation policy applies equally to telehealth appointments.

VIII. CONSENT

☐ I have read and understand this consent, and I have had the opportunity to ask questions.

☐ I understand that I may withdraw consent for telehealth at any time and request in-person services.

☐ I consent to receive psychological services via telehealth.

Patient / Guardian Signature: _____ Date: _____

Printed Name: _____

Provider: Mark R. Dell, Psy.D. NJ License #: 35SI00480700