DR. JOHN "JACK" CROSSEN
COUPLES DOING BETTER

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Telepsychology Informed Consent

I consent to engage in telepsychology. I understand that telepsychology includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. Examples of this include, but are not limited to: internet, email, text, or telephone-based therapy.

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

I have the right to withdraw consent for telepsychology at any time.

The laws that protect the confidentiality of my medical information also apply to telepsychology. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality as noted in companion informed consent forms.

I understand that there are risks and consequences associated with the use of telepsychology. These may include but are not limited to the possibility, despite reasonable efforts on the part of my psychotherapist, that:

- The transmission of my medical information could be disrupted or distorted by technological interruptions or failures. (For example, internet signal may be lost, calls may be dropped, text messages or

- The transmission of my medical information could be interrupted by unauthorized persons despite rea- sonable efforts on the part of my therapist to ensure that information is protected·.

- The electronic storage of my medical information could be accessed by unauthorized persons despite reasonable efforts on the part of my therapist to ensure that information is protected.

- Misunderstandings can more easily occur, especially with electronic delays, or difficulty understanding tone or intent in written or spoken communication. This includes the risk of cultural misunderstandings or misinterpretations of information due to delays or lack of being able to incorporate the full spectrum of body language.

I accept these risks as a part of my informed decision to engage in telepsychology.
I have the right to ask for clarification from my provider at any time.

I understand that telepsychology-based services and care may not yield the same results nor be as complete as face-to-face services.

I understand that I may benefit from telepsychology, but results cannot be guaranteed or assured.

I understand that I have the right to access my medical information and copies of medical records resulting from telepsychology in accordance with Oregon law.

Location and Jurisdiction

I understand that the laws that govern my provider's license to practice extend to telepsychology, and therefore he/she/they may only provide telepsychology in jurisdictions where he/she/they are licensed. I need to inform my provider if I am requesting telepsychology services from outside the State of Oregon to ensure that my provider is able to care for me if I am in a different state.

Billing and/or Cost of Telepsychology

I understand that Dr. Crossen does not accept or bill insurance coverage.

Fees are specified in a separate Form. Invoices are usually sent monthly and due on receipt unless otherwise mutually agreed.

I have read and understand the information provided above, which has also been explained to me verbally. I understand I am able to ask questions and seek ongoing clarification from my provider.

Name ____

Signature ______________________________________ Date _________________