Elanna Lazaruk, PsyD
New York State Licensed Psychologist
Phone: (914) 500-8448

Informed Consent for Telehealth Services and Emergency Response Policy

I _____, consent to engaging in telehealth with Elanna Lazaruk, PsyD as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

Telehealth refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All interactions with Dr. Lazaruk will fall under this term. When using technology, there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). Dr. Lazaruk will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with Dr. Lazaruk. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows psychologists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of one's choosing. In order to protect patient confidentiality and to facilitate the security of patient information as much as possible, here is a list of recommendations:

* Engage in sessions in a private location where you cannot be heard by others.
* Use a private phone.
* Do not record sessions which risks someone finding and listening to them.
* Password protect any technology used to interact with Dr. Lazaruk.
* Always log out or hang up once sessions are complete. If using a shared computer, clear the cache also.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. (See your copy of office policies and HIPAA form).

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Elanna Lazaruk, PsyD utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.

4. Elanna Lazaruk, PsyD follows regulations for telehealth and has received training to provide telehealth services.

5. I have chosen to engage in telehealth consultation based on discussion and agreement with my health care provider.

6. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

7. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a private location of my choosing. I agree to let Dr. Lazaruk know my physical location at time of session.

8. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that Dr. Lazaruk or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

9. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

10. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. I understand that I may also be asked to verify my identity.

11. I understand time zone differences and agree to coordinate accordingly.

Payment for Telehealth Services

Payment for the sessions is due at the beginning of every session. Elanna Lazaruk, PsyD will keep a credit card on file to charge for each session.

Disruption Protocol

In the case that a session is disrupted by a hardware, software, or connectivity reason, both parties will make reasonable attempts to re-establish effective contact. These steps may include: plugging your device in to charge, moving to a different area (still private) with better service or wi-fi, restarting your device, etc. If contact cannot be regained after 5-10 minutes, your clinician will attempt to contact you via phone. If contact cannot be regained after 10 minutes, session will be rescheduled for a later date/time.

Crisis Response

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital emergency department or crisis facility.

I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that cannot be addressed properly remotely, Dr. Lazaruk may determine that I need a higher level of care and Telehealth services are not appropriate.

Emergency Contact Person

Please provide at least one emergency contact person who Dr. Lazaruk may contact on your behalf in a life-threatening emergency only. I understand Dr. Lazaruk will only contact this individual in the extreme circumstances stated above.

Name:_____ Phone:_____

Name:_____ Phone:_____

By signing this form, I certify:
• That I have read or had this form read and/or had this form explained to me and consent to receive telehealth consultation/therapy
• That I fully understand its contents including the risks and benefits of the procedure(s).
• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. This document was updated in August 2020.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.
Patient Name: _____

Signature: _____ Date: _____

Fill out if Patient is under 18 years of age:

Parent/Guardian Name: _____ Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____