Stacey Maples, PhD
866-590-6838
1407 S. Elliott
Aurora MO 65605

# Telehealth Consent

*By participating in telehealth, you agree and understand the following:*

*The benefits and risks of telehealth may differ from traditional office visits.

* Confidentiality still applies. Neither of us will record sessions without express permission of the other.

*You will need to use a webcam and audio during the session. If our session is disrupted, we can try to resume but if technical problems persist, we may have to finish the session via telephone.

*It is important to be in a quiet private place for our session that is free of distractions.

*It is important to use a secure internet and not free public networks.

*It is important to be on time and to let me know if you cannot keep your scheduled tele-session.

*Please make sure I have up to date contact information for you in the event of an emergency. I will also require the contact information for an emergency contact person.

*As your psychologist, I may deem that telehealth is no longer appropriate and that we will need to resume regular office visits.

| | |
|---|---|
| Printed Name: and Preferred Phone Number: | |
| Emergency Contact Name & Phone Number: | |
| Nearest Hospital to your Location: | |
| By signing here, I authorize the use of the above information. | Signature / Date |