INFORMED CONSENT
FOR
TELEPSYCHOLOGICAL SERVICES

I _____

Understand that Telepsychotherapy differs from conventional Psychotherapy sessions;

1. Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
2. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
3. It is important to use a secure internet connection rather than public/free Wi-Fi.
4. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
5. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
6. We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
7. You should confirm with your medical aid that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
8. As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer an appropriate level of care and that we should resume our session's in-person.

1. PATIENT DETAILS

Surname: _____

First name(s**):** _____ Initials**:** _____

Residential Address: _____

_____Postal Code: _____

Postal Address:

_____Postal Code: _____

Email: _____

Telephone: Work: _____ Cell: _____

Date of birth: Year_____Month_____Day____

MEDICAL AID DETAILS

Medical Aid: _____

Medical Aid Number:_____

PERMISSION TO CONTACT YOU

SMS ☐ EMAIL ☐ VOICE ☐ ANY ☐ NONE ☐

Please provide emergency contact number; _____

Please provide address from where the session will be held (if different from above);

PERMISSION TO CONTACT REFERRING PRACTIONER OR OTHER PARTIES;

In order to communicate about you and your treatment, you have to give your permission. This consent is only valid for the duration of your treatment and may be withdrawn anytime in writing. In addition, you consent to other treating practioners to communicate about your treatment.

ANY INFORMATION DISCLOSED TO THE BELOW MENTIONED PERSON/S WILL BE DISCUSSED WITH YOU BEFOREHAND

PSYCHIATRIST/GP **YES** ☐ **NO** ☐

PARENTS: **YES** ☐ **NO** ☐

SPOUSE **YES** ☐ **NO** ☐

PAYMENT AGREEMENT

Appointments are payable at time of consultation. It remains your responsibility to submit your claim to the Medical Aid. Fees are above medical aid rates. Appointments not cancelled 24hrs in advance will be charged.

PROTECTION OF PRIVATE INFORMATION

Based on your consent provided your personal data will be protected in accordance with your consent and applicable law. (E.g. collection, use, store and share of data).

This practice is obligated to protect personal information of patients, legally and ethically, at all times. I thus understand that no personal information will be disseminated to any third party without my expressed informed consent.

Your contact details are only for the purposes of the practice records unless otherwise stated with your consent. Detailed policy is available on request.

ICD- 10 CODES

This practice is obligated to disclose diagnoses to medical schemes with each claim in the form of a diagnosis code. In this regard, I acknowledge and understand that diagnosis code will be provided with my personal details to my medical scheme in order to claim for services rendered.

SIGNATURE: _____ DATE: _____

You will receive an email few minutes prior to your session with a ZOOM link. Please follow the link to join the session.

DR MICHAEL H. NISS
Melrose North Medical Centre
0118809072