SARAH LEVOY, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
CA PSY17161

Informed Consent for Video Therapy Session

Client Name: _____

Please read the following video therapy consent and sign below.

1. I understand that I am about to engage in a video therapy session with my provider, Dr. Sarah Levoy.

2. I understand that the video conferencing technology will not be the same as an in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.

3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate for the situation.

4. My provider agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my provider if there is another person present during the session or if I wish to record the session.

5. I understand that there are alternatives to a video therapy session available, including the option of finding another provider in my area or coming into the office.

6. I understand that I can direct questions about this video therapy session at any time to my provider, Dr.Sarah Levoy.

7. I understand that this consent will last for the duration of the relationship with my provider, including any additional video therapy sessions I may have; I can withdraw my consent for a video therapy session at any time.

8. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a video therapy session as they would to an in-person session.

9. I agree to work with my provider to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.

10. I understand that my provider may decide to terminate video therapy services, if they deem it inappropriate for me to continue therapy through video sessions. My provider will work with me to identify another provider for in-person care if they are unable.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to participation in a video therapy session(s) with Dr. Sarah Levoy

_____ _____

Client's/parent/guardian signature Date