Jersey Shore
Psychiatric Services, LLC

COVID-19 Outbreak Virtual Services

Due to the current events surrounding the Coronavirus outbreak, we at Jersey Shore Psychiatric Services wants to ensure that our patients are safe while still making our care available to them. We are working to determine if the insurance companies will cover the virtual services, but due to the high demand currently we are not able to know for sure with some plans.

These services will be available to our patients in case of an illness that prevents you from being able to come for an appointment physically, or in case of a mandatory shut down. We will extend the courtesy during this time, that if your insurance does not cover the virtual services, we will waive part of the office fee, and you will be charged $60.00.

By signing below, you are not bound to accepting the virtual services. You are acknowledging the fee of $60.00 for established patients, and $150 for new patients, in the event that your insurance does not cover the visits.

_____ _____
Patient Name (please print) Date

_____
Patient Signature

5 Professional Circle Suite 110 Colts Neck, NJ 07722
P: 848-482-7764 F:732-308-2227

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Teletherapy Consent Form

I, _____(patient) hereby consent to engage in teletherapy with _____ (Clinician). I understand that "teletherapy" includes, consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. I understand that teletherapy also involved the communication of my medical/mental information, both orally and visually.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. HIPAA confidentiality requirements apply the same for teletherapy as for face-to-face psychotherapy. Information is not released to anyone without your prior approval, as required by law.

3. I understand that there are risks from teletherapy (although extremely unlikely), including but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that the transmission of my information could be disrupted or distorted by technical failures; the transmission could be interrupted by unauthorized persons; and/ or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that teletherapy based services may not be as complete as face to face services. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my clinician, my condition may not improve. I understand that I may benefit from teletherapy, but the results cannot be guaranteed or assured.

5. I accept that teletherapy does not provide emergency services. My clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room.

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6. I understand that I am responsible for the following:
    a. Providing a necessary computer, telecommunications equipment, and internet access for my teletherapy sessions.
    b. The security of information on my computer.
    c. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.
    d. If I decided to keep copies of emails or communication on my computer, it is up to me to keep that information secure.
    e. I understand that I will not record any teletherapy sessions without prior written consent from my clinician. I will inform my clinician if any other person can hear or see any part of our session before the session begins or as it continues.

Patient Consent to the use of teletherapy:

I have read, understand, and agree to the information provided above. I have discussed this document with my clinician and all my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of teletherapy in my psychological care and authorize Jersey Shore Psychiatric Services, LLC to use teletherapy in the course of my diagnosis and treatment.

_____ _____
Patient Signature Date

_____
Print Name

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