WOODS CREEK PSYCHOLOGICAL GROUP
A Professional Corporation
103 S. Forest Road, Sonora, CA 95370
Phone: (209) 533 – 1699 Fax: (209) 532 – 0699

Informed Consent for Video Therapy Session

Patient Name: _____

Thank you for choosing Woods Creek Psychological Group (WCPG). Please read the following video therapy consent and sign below. If you have any questions, please let your therapist know, and she will be happy to answer them.

1. I understand that I am about to engage in a video therapy session with my therapist.

2. I understand that the video conferencing technology will not be the same as an in-person session with a therapist due to the fact that I will not be in the same room as my therapist. 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 therapist or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate for the situation.

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

5. I understand that there are alternatives to a video therapy session available, including the option of finding another therapist to see in-person if available in my area.

6. I understand that I can direct questions about this video therapy session at any time to my therapist.

7. I understand that this consent will last for the duration of the relationship with my therapist, including any additional video therapy sessions I may have; I can withdraw my consent for a video therapy session at any time, and my therapist will work with me to find a suitable alternative.

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 therapist 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 therapist may decide to terminate video therapy services, if they deem it inappropriate for me to continue therapy through video sessions.

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 my therapist.

Patient Signature _____ Date_____

Emergency Contact: Name: _____

Phone #_____