JOHN MARKEY
Forensic Psychology Services

P 215.348.2757 F 215.348.4125

80 NORTH MAIN ST., SUITE 1C
DOYLESTOWN, PA 18901

WWW.MARKEYPSYCH.COM

Informed Consent Agreement for Telepsychology

This Informed Consent for Telepsychology contains important information focusing on conducting psychotherapy using the phone or the Internet. Please read this carefully and ask any questions you may have prior to signing. Once you sign this document, it will represent an agreement between yourself and Dr. Markey.

Credentials

Dr. Markey has a doctorate degree in Clinical Psychology and is licensed in the states of New Jersey and Pennsylvania to practice as a Psychologist. He also holds certification as a Certified Alcohol and Drug Counselor in the states of Delaware and Pennsylvania.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the patient and clinician can engage in services without being in the same physical location. This is necessary during the COVID-19 crisis by ensuring continuity of care due while services are not permitted to take place in person. Telepsychology, however, requires technical competence of both patient and clinician. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. These risks will be discussed throughout this document.

Patient Portal

Dr. Markey has the ability to offer you voluntary enrollment in his Patient Portal. The Patient Portal allows many benefits, including the ability to view balances, payments and appointments. You may also request appointments through the portal. The Patient Portal also allows you to securely send messages to Dr. Markey and to complete any clinical documents requested of you.

Electronic Communications

Dr. Markey is currently utilizing a HIPAA compliant telepsychology platform. You may need to have certain computer or cell phone systems to use telepsychology services. You are solely responsible to have any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, please utilize the main office phone number, or you may sign up for the patient portal and send secure emails to discuss any administrative issues. This includes things like setting and changing appointments, billing matters, and other related issues. Please be aware that Dr. Markey cannot guarantee the confidentiality of any information communicated by standard unsecure email. Therefore, Dr. Markey will not discuss any clinical information by unsecure email and prefers that you do not either.

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, an emergency plan will be developed before engaging in telepsychology services. You will be asked to identify an emergency contact person who is near your location and who Dr. Markey can contact in the event of a crisis or emergency to assist in addressing the situation.

If there is a clinical emergency, only telephone should be used to make contact, as the phone is directly monitored. If you are unable to reach Dr. Markey and feel that you cannot wait for him to return your call, contact your family

physician, Lenape Valley Foundation's crisis line or the nearest emergency room. If Dr. Markey will be unavailable for an extended time, you will be provided with contact information to utilize if necessary, during any absence.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call Dr. Markey back; instead, call 911, contact Lenape Valley Foundation's crisis line or go to your nearest emergency room. Contact Dr. Markey after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and Dr. Markey will wait two minutes and then re-contact you via the telepsychology platform on which was agreed to conduct therapy. If you do not receive a call back within two minutes, then call the main phone number (215-348-2757).

Confidentiality

Dr. Markey has a legal and ethical responsibility to make best efforts to protect all communications that are a part of telepsychology. However, the nature of electronic communications technologies is such that Dr. Markey cannot guarantee that communications will be kept confidential or that other people may not gain access to treatment related communications. Dr. Markey makes every attempt to utilize the most updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that electronic communications may be compromised, unsecured, or accessed by others. It is important for you to make sure you find a private place for sessions where you will not be interrupted. You should participate in sessions only while in a room or area where other people are not present and cannot overhear the conversation.

Release of Information Without Patient Consent: Dr. Markey is a mandated reporter by law and must report to the appropriate authorities any of the following:

- Suspicion of or knowledge of child abuse and/or neglect
- Suspicion of or knowledge of elder/disabled person abuse and/or neglect
- Clear intention on your part to do serious bodily harm to self or commit suicide
- Clear intention on your part to do serious bodily harm to another person/the public or commit homicide
- In response to court order

Fees

The same fee rates apply for telepsychology as apply for in-person psychotherapy. Please contact your insurance company prior to engaging in telepsychology sessions in order to determine whether these sessions will be covered. Please note that during the current COVID-19 crisis, most major insurance providers have agreed to reimburse for telepsychology sessions with patient copays remaining the same. At this time, no late cancel or no-show fees will be charged. However, Dr. Markey requests your timely notice if you are unable to make your scheduled appointment so that it may be offered to someone else. If you are uninsured, you may request a sliding scale fee by contacting the office number (215-348-2757).

Dr. Markey accepts payment in the form of credit or debit cards only, as the session needs to be paid for at the time the session is conducted. You may leave a credit card on file if you prefer. You may also pay online at www.markeypsych.com.

Record Keeping

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. Dr. Markey will maintain a record of your sessions in the same way records of in-person sessions are maintained.

Appointment Reminders

Dr. Markey has the ability to offer you appointment reminders if you choose. Reminders are sent in the form of email, voice call or text message. The reminders are sent 48 hours in advance and simply state your appointment date and provider only.

I have read this Informed Consent Agreement for Telepsychology and my signature indicates that I understand the information, agree with the conditions of services that are either stated or implied here, and agree to comply with them. I understand I have the right not to sign this form and can choose to discuss my concerns before treatment begins. I understand that once treatment begins, I still retain the right to withdraw my consent to participate at any time. I voluntarily consent to participate in telepsychology services with Dr. Markey.

Patient	Date
John E. Markey, Psy.D.	Date

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Patient Information

Name: _____ Gender: _____ DOB: _____
First Middle Last

SSN: _____ Email: _____ Phone: _____

Address: _____

_____

Emergency Contact: _____
Name Phone Relation to Patient

How did you hear about us? _____

Would you like to be enrolled in the Patient Portal? ☐ Yes ☐ No

Would you like reminders of your appointments? ☐ Yes ☐ No

If yes, choose: ☐ Text Message ☐ Voice Call ☐ Email

Insurance: _____
Name of Insurance Company

_____
ID Number Group Number

_____
Policy Holder's Name, DOB and Relationship to Patient

_____
Policy Holder's Address

Reason for Seeking Treatment: _____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

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Authorization for Release of Protected Health Information

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

I authorize the release information as described below:

Facility/Person to Release Records	**Facility/Person to Receive Records** (Insurance Info:)
John E. Markey, Psy.D., CADC	Insurance Name: _____
Phone: 215-348-2757	Phone: _____
Fax: 215-348-4125	Fax: _____
Address: 80 North Main Street, Suite 1C	Address: _____
Doylestown, PA 18901	_____

Records are requested for the purpose of: (check at least one)

☐ Continuing Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other: _____

Specific information to be released: (check all that apply)

☐ Discharge Summary/Instructions
☐ Medication Administration Records
☐ Psychiatric/Psychological Evaluation
☐ Psychiatrist/Physician Orders
☐ Court Ordered Evaluation
☐ Psychological/Psychiatric Progress Notes
☐ Current Medications
☐ Complete Medical or Psychiatric Record
☐ Submission of Insurance Claim(s)
☐ Other, specify: _____

I understand that my consent to Authorization for Release of Protected Health Information is governed by the Health Insurance Portability and Accountability Act of 1996 and may not be a condition for me to receive treatment services. I understand that Federal rules may prohibit re-disclosure of these records to another party, unless expressly permitted by the written consent of the person to whom it pertains. I understand that this authorization is effective beginning on _____ and expires on _____. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. I understand that I cannot revoke any information that has already been released under this authorization.

_____ _____
Signature of Patient Date of Signature

_____ _____
Signature of Witness Date of Signature