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L I C E N S E D P S Y C H O L O G I S T P R O V I D E R

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## Teletherapy Informed Consent Form

I \_\_\_\_\_ hereby consent to engage in teletherapy with J. Gary Dolinsky, Ph.D. 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 involves the communication of my medical and psychological 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) The laws that protect the confidentiality of my medical information also apply to teletherapy. as such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality which are discussed in detail in Dr. Dolinsky’s general Psychotherapy Informed Consent/Agreement I received along with this consent form.
- 3) I understand that there are risks and consequences from teletherapy including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Dolinsky that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by.

unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons

4) In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if Dr. Dolinsky believes I would be better served by another form of therapeutic services (e.g., face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the effort of Dr. Dolinsky, my condition may not improve and, in some cases, may even get worse.

5) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

6) I accept that teletherapy does not provide emergency services. During our initial session, Dr. Dolinsky 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 department for help. I can also contact North Shore Emergency Services (north of Boston region) at 866-523-1216. If I am having suicidal thoughts or making plans to harm myself, I can also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support.

7) I understand that I am responsible for (1) – provide the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) - the information security on my computer, and (3) – arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.

8) I understand that while email may be used to communicate with Dr. Dolinsky, confidentiality of emails cannot be guaranteed.

9) I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law(s).

I understand that Dr. Dolinsky uses a HIPAA compliant software called VSEE which is a free application and that Dr. Dolinsky will send me a link to VSEE should I decide I want the option of having sessions via the teletherapy.

I understand that Dr. Dolinsky will conduct my teletherapy sessions from either his office in Beverly or from his home office in Danvers. I understand that I am able to connect via smart phone, tablet, or computer/laptop from anywhere I have an internet connection.

*PLEASE NOTE: Due to State Licensing Laws for Psychologists, I can only provide you with Teletherapy if you are within Massachusetts at the time of your therapy appointment.*

Payment is collected by credit or debit card using the Square software. Payment is required at the time of the session. Dr. Dolinsky will charge your card at the time of the session and send you a receipt via email or text.

I have read, understand and agree to the information provided above.

\_\_\_\_\_  
**CLIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PRINTED NAME**