BASSMAN MENTAL HEALTH SERVICES, INC.

Dr. Stuart W. Bassman
Mr. Daniel Bassman
Ms. Lendsey Webb
Dr. Rachel Nienaber
Dr. Steven Patrick
Ms. Maria Roth
Ms. Sandra Ray

Office Phone Number - (513) 314-6111
drstuartbassman@gmail.com
Drstuartbassman.com
1955 Mears Ave., Cincinnati, Ohio 45230
NOTE: The following letter has been adapted from a template provided by the American Psychological Association

INFORMED CONSENT CHECKLIST FOR TELE-THERAPEUTIC including VIDEO-CONFERENCING SERVICES.
As the pandemic continues as well as the importance for the continuity of therapy and assessment services, please sign below your consent and agreement to participate in these services:

Patient Name: ____

I understand and consent to the following: Tele-therapy is a form of mental health services provided by telephone and/or internet technology. These services are provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face communication. Tele-therapy has the same purpose or intention as therapy or assessments that are conducted in person.

- Tele-therapeutic services has potential benefits (continuity of treatment, safer than an office visit, no travel time) and risks (limits of confidentiality, technology issues including interruptions, unauthorized access, and technical difficulties, and lack of a deeper personal interaction) than in-person sessions.
- Confidentiality still applies for tele-therapeutic services, and the sessions will not be recorded.
- I agree to use the tele-therapy platform selected for our virtual sessions and I understand that I may need to use a webcam or smartphone during the session.
- I understand that It is important to be in a quiet, private space during the sessions.
- I understand that it is important to use secure internet connection rather than public/free Wi-Fi.
- I understand to be prompt and ready for the sessions. If I need to cancel or change my tele-therapy, I will notify the therapist at least 24 hours in advance by phone or email to avoid financial charges. I understand that I am under no obligation to use tele-therapy. I may decline this service at any time without jeopardizing my access to future care, services, and benefits.
- I understand that it is important to have a back-up plan (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems.
- I understand that due to the nature of tele-therapy, we need a safety plan that includes at least one emergency contact & the closest Emergency Room, in the event of a crisis situation.

I understand that in the event of an emergency, this office is authorized to contact:

Name, phone, email ____

Closest Emergency Room ____

Patient's Signature: ______________________________ Date: ____________________

If a Minor/Patient's Legal Representative: ______________________________

THIS PAGE IS BLANK