MICHELE BOGRAD, Ph.D.

16 Webber Avenue Bedford, MA 01730

Licensed Psychologist

mbogradphd@gmail.com 781-643-5451

CLIENT SIGNATURE PAGE

OFFICE PRACTICE POLICIES

Please sign, date, and return this page to me.

I acknowledge the receipt of information describing the professional psychology practice of Dr. Michele Bograd, Ph.D. I have read this material which includes specific information about the following topics: office hours, length of sessions, availability, emergency procedures, vacation coverage, cancellations, billing procedures and collection of fees, insurance reimbursement and HIPAA, confidentiality and its legal and professional exceptions, the use of social media, and other rights and expectations. I understand that this material offers an overview of information pertinent to my treatment but is not meant to be an exhaustive document and is not a substitute for legal consultation on specific matters summarized within.

Print Name

Sign Name Date

Print Name

Sign Name Date

MICHELE BOGRAD, Ph.D.

Licensed psychologist

16 Webber Avenue Bedford, MA 01730

mbogradphd@gmail.com 781-643-5451

CLIENT SIGNATURE PAGE

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION (HIPAA)

Please sign, date and return this page to me

This form is an agreement between you and Michele Bograd, Ph.D. When I use the word "you" below it will mean your child, relative, or other person if you have written their name here as their designated representative.

By signing this form, you are agreeing that you have read and understand my Notice of Privacy Policies and you are agreeing to let me use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand my Privacy Policies above before signing this Consent form.

Print Name

Write Name Date

Print Name

Write Name Date

Michele Bograd, Ph.D.

16 Webber Avenue Bedford, MA 01730
781-643-5451 www.michelebogradphd.com

CLIENT SIGNATURE PAGE

INFORMED CONSENT FOR TELETHERAPY

Please sign and return this form to me

This Informed Consent for Teletherapy (also known by other names) contains important information focusing on the remote delivery of psychotherapy through technology-assisted media. This includes a wide array of clinical services and various forms of technology. Not all of these forms or technology are secure or HIPAA compliant. Teletherapy is covered by the same laws and ethics that guide in-office, in-person, face-to-face mental health service. My standard policies and consents apply to teletherapy services, but there are additional components detailed in this consent that cover the unique characteristics of telehealth services. Please read this carefully and let me know if you have any questions. When you sign this document, in person or electronically, it will represent an agreement between us.

_____

_____

Print Name of Client or Guardian and then Signature Date

Addendum to Teletherapy Informed Consent

EMERGENCY CONTACT:

Because teletherapy is not an in-person meeting, it potentially makes it more difficult to assess a client's wellbeing or coordinate a response should face-to-face care be necessary. For this reason, therapists have been advised to get the contact information of a person who could potentially provide in-person support and collaboration. Commonly, this is a family member over the age of 21 or a close friend or neighbor. I will not contact this person except if you ask me to or in cases that I deem sufficiently urgent enough that online contact is not sufficient.

I require this information in order to do teletherapy. You providing the information constitutes informed consent to this practice. You can rescind consent or provide another name in writing to me.

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone number: _____

Emergency Contact Email: _____

USE OF NON-HIPAA COMPLIANT TECHNOLOGY FOR COMMUNICATION

Many clients prefer email for scheduling purposes or for communication of non-clinical information. It is my preferred method for scheduling due. Additionally, with Teletherapy, cellphone or landlines are often useful if there are technological issues or unavailability of WiFi. However, these technologies are not HIPAA compliant as required for therapists.

If you want to use these technologies, acknowledge that you know they are not HIPAA compliant, and are willing to waive the HIPAA requirements, please check which of these forms you are giving me permission to use. Your checking them is demonstrating informed consent of the risks to privacy and giving me permission to employ them when necessary.

_____ email

_____ phone number(s) you have provided me

_____ texting. Remember: I do not use texting in my practice except for special circumstances

_____

Print Name of Client or Guardian and then Signature Date