MPG Informed Consent for Mental Health and Telehealth Treatment

Patient Name: _____
Date of Birth: _____

Please review and acknowledge by checking each item and initialing and dating at the bottom.

☐ **Initial Intake and Diagnostic Evaluation**

The first session will involve an initial evaluation, during which the clinician will gather detailed information about yourself/your child, including presenting concerns, symptoms, and adaptive functioning. You may be asked to complete formal measures or sign consent to contact other providers or educators. Relevant medical, educational, or treatment records may also be requested.

After the intake, the clinician will review their initial impressions, explain the treatment plan, and discuss potential goals, modalities, and outcomes. If you have questions about the treatment plan, possible risks, or alternative options, you are encouraged to ask. Choosing a therapist should be a careful decision, and if concerns arise, we will work with you or refer you to another provider.

☐ **Psychological Services**

Therapy can vary based on the therapist's approach, the client's goals, and the nature of the presenting issues. Treatment methods may include Cognitive Behavioral Therapy (CBT), Parent-Child Interaction Therapy (PCIT), Dialectical Behavior Therapy (DBT), Parent Management Training, or other evidence-based interventions.

☐ **The Therapy Process and Scope of Practice**

Psychotherapy may involve discussing distressing topics, which could result in difficult emotions such as sadness, frustration, or guilt. While these experiences are challenging, therapy has been shown to lead to improved relationships, emotional regulation, and symptom reduction. However, results cannot be guaranteed.

Please note that clinicians at Manhattan Psychology Group do not provide custody evaluations or recommendations, medication management or prescriptions, or legal advice, as these services are outside the scope of our clinical practice.

☐ **Termination of Services**

Your clinician will monitor progress throughout treatment and assess whether continued services are beneficial. If it is determined that our services are no longer a good fit, you may be referred to another provider. You may also choose to discontinue services at any time. Upon request and written authorization, your clinician can assist in coordinating care with your next provider.

☐ **Informed Consent for Telehealth Services**

Telehealth includes the delivery of therapy or evaluation services through interactive audio-video communication. By consenting to telehealth, you acknowledge that you have the right to withhold or withdraw consent at any time. All confidentiality protections apply to telehealth services, except in situations where disclosure is legally required, such as risk of harm to self or others or suspected child abuse.

While efforts are made to ensure secure communication, telehealth services carry potential risks, including technical issues or unauthorized access to electronic information. Additionally, telehealth may not always be as complete or effective as in-person care. If clinically indicated, your provider may recommend a transition to in-person sessions. You have the right to access your telehealth records in accordance with New York State law.

To participate in telehealth sessions, you agree to be in a private, quiet space free of distractions, use a secure internet connection rather than public Wi-Fi, and ensure access to a device with a functioning camera and microphone. You are expected to attend sessions on time and to notify your provider in advance if you need to cancel or reschedule; standard cancellation policies apply.

For safety and continuity of care, you will be asked to provide a backup contact method in case of disconnection, identify your nearest emergency room, and list at least one emergency contact. For minor clients, written permission from a parent or legal guardian is required to participate in telehealth services.

By signing below, you acknowledge and accept the conditions of both in-person and telehealth services.

Acknowledgment

Patient/Parent/Guardian Initials:_____
Date: _____