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TELEHEALTH PARTICIPATION VIA VIDEO CONFERENCING AGREEMENT

In lieu of an in-person therapy session, it may be viable for treatment delivery to occur via interactive video-conferencing (i.e., virtual “face-to-face” sessions) instead of, or in addition to, in-person sessions. Video conferencing (VC) is a real-time, interactive audio and visual technology that enables me to provide mental health services remotely.

The VC system I use (www.zoom.us) is HIPAA-compliant. This means that this site follows HIPAA (Health Insurance Accountability and Portability Act) standards of encryption and privacy protection, and does not store our conversation. You will not have to purchase a plan in order to join our online meeting. You will need to download Zoom ahead of our session, but can sign up for the plan that is free.

Treatment delivery via VC may be a preferred method due to convenience, distance, or other circumstances. Although VC may be used when the clinician and client are in different locations, licensure regulations require that a session needs to be conducted: in the state in which the clinician is licensed and the client is located (Washington, DC) or when the client is located in a state that participates in PsyPACT regulation of telehealth, as I am a licensed member of this telehealth regulating body. Exceptions can be made if temporary permission is available from another state or if ethics suggest that conducting sessions in this way is justified.

Please understand that although I can reasonably control privacy in my environment, I cannot guarantee privacy in yours. It is your responsibility to ensure that you/your child or teen is in a private space with no one else in the room in order to maintain your/their confidentiality. A headset is recommended if there is a concern of voices being heard from another room. If someone else is present in the room, even temporarily passing through, please inform me immediately. Please identify a private environment ahead of our session, and also test that it has a stable internet connection.

I recommend building in a few minutes prior to your session in order to enter it thoughtfully and consider what you may want to discuss. Additionally, you may find it helpful to give yourself a few minutes to process it afterward before moving on to other activities.

CPT (current procedural terminology) coding for VC is the typical therapy session procedure code followed by a modifier for video session (-95) and a place of service code (POS 10). Many insurance companies reimburse video sessions in the same way as in-person sessions, but *please inquire with your own insurance company regarding the particulars of your potential reimbursement.*

Risks of VC in general may include (but are not limited to): lack of reimbursement by your insurance company, the technology being delayed or dropping due to problems with internet connections, or a breach of information that is beyond our control. *If the internet connection drops and we cannot get the connection back, please have your telephone nearby and we will complete our session by phone.*

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Clinical risks of VC may include discomfort with virtual face-to-face versus in-person treatment, difficulties interpreting nonverbal communication, and importantly, limited access to immediate resources if risk of self-harm or harm to others becomes apparent. I will weigh these advantages against any potential risks prior to proceeding with telehealth sessions and will discuss the specifics of telehealth with you before using the technology.

By signing this document you are stating that you are aware and agree that I may call your emergency contacts or the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911.

Below, please include the names and telephone numbers of your emergency contacts AND resources local to where you are having your telehealth session/s. You are granting permission for me to contact the appropriate person/agency in the case of emergency.

Psychiatrist (or Primary Care Provider) Name

Telephone number(s)

Family Member Name/s & Relationship

Telephone number(s)

LOCAL Family or Friend Name & Relationship

Telephone number(s)

LOCAL Emergency Services
(local area code + 911)

Telephone number

Name of nearest hospital with an emergency room

Telephone number

Email address to receive Zoom link

By signing this document you are also declaring your agreement with the following statement: I have read this document and have had the opportunity to ask questions. I understand the risks/limitations and benefits of video conferencing. I agree to telehealth sessions via video conferencing. I agree not to record (audio or video) any portion of our video conference sessions.

Signature (of adult client or legal guardian if client is minor)

Date

Printed Name of Signer

Printed Name of Minor Client, if applicable