D. Russell Bishop, Psy. D.
Clinical Psychologist
4700 N. Cloverdale Road, Boise, Idaho 83713
(208) 999-0785

Electronic Communcations Agreement

Patient Name: _____

- Electronic communications may be sent to me at Dr.Russell@drbishoppsychologist.com (a secure email address) and will be stored as part of your patient's record in a manner compliant with HIPAA standards. Your e-mail service provider may not provide security and your information could potentially be intercepted and viewed by individuals who are unauthorized to view that information. By signing this addendum you are agreeing that as part of the services I provide I may send you e-mail.
- If you chose to send me an electronic message that requires my response, I will respond with a phone call as soon as possible.
- There may be potential benefits to receiving telepsychology services (e.g. convenience when transportation for an in office visit is limited) or associated risks (e.g. sudden and unpredictable disruption of communications).
- If it is determined telepsychology services are indicated we will use a telephone or https://doxy.me/drrussellbishop as a technology platform for these services, and if it is determined telepsychology services are not indicated we will have in-person appointments.
- We agree that no one will record our telepsychology sessions.
- You will need to use a technology device that adequately facilitates the telepsychology services interaction.
- It is important that during the telepsychology session you are in a quiet, private space that is free of distractions (including cell phone, or other devices) and persons who may breach the confidentiality of our telehealth session during the session.
- For your privacy consider using a secure internet connection rather than public/free Wi-Fi.
- Because of the risk of sudden and unpredictable disruption of telepsychology services we need a back-up plan. Please provide a phone number where you can be reached to continue the session: _____. I may be reached at (208) 999-0785.
- We need a safety plan that includes at least one emergency contact (name and phone number) _____ and the name and phone number of the closest emergency room to your location _____.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND ALL OF THIS AGREEMENT AND AGREE TO ITS TERMS.

_____ _____

Patient Signature (if 14 years of age or older) Date | Parent or Legal Representative Signature Date

_____

Witness Signature Date