

Informed Consent for Treatment
(Including Virtual Reality Treatment)
Revised 1/2009

Virtually Better is dedicated to helping people improve the quality of their lives through psychological therapy.

Therapy Agreement

I understand that treatment at Virtually Better may involve discussing issues that may be uncomfortable. I also understand that at times my therapist may ask me to challenge myself in-between therapy sessions, which also may be uncomfortable, and is designed to be helpful.

If appropriate, as determined by my therapist's professional judgment, virtual reality environments may be used to assist in the therapeutic process. I understand that this treatment is a relatively new method for conducting exposure therapy. Using virtual reality environments involves wearing a head-mounted display, which is like a helmet with mini-television screens in front of my eyes. The purpose of the virtual environment is to help me feel as if I am really in the situation of which I am afraid. Thus, virtual environments may elicit anxiety, which is consistent with the treatment I wish to receive and designed to help me overcome my fears.

I understand that it is possible to experience transient adverse side effects from virtual environments, including motion sickness, disorientation, and dizziness. I agree to inform my therapist if I experience such side effects and wait until I am no longer experiencing any such effects before beginning other activities, such as operating a motor vehicle. A very small portion of the population may experience epileptic seizures when viewing certain kinds of flashing lights or patterns that are commonly present in daily activities. Such people also may experience seizures while using the head-mounted display. I agree to inform my therapist of any past epileptic activity, as this may affect their professional judgment about utilizing the virtual environments as part of my planned treatment.

As determined by my therapist's professional judgment, it may be recommended that therapy sessions be conducted in public places where I may confront my fear "in the real world." Examples of such places include elevators, while driving, at the airport and other sites deemed appropriate and agreed upon. I understand that while conducting therapy in public places, my confidentiality cannot be insured. I also understand that my therapist does not control and therefore cannot be held responsible for adverse incidents that may occur while conducting therapy in public places. We will arrange for emergency care if you are injured by this therapy/research. However, Virtually Better has not set aside funds to pay for this care or to compensate you if a mishap occurs. If you believe you have been injured by participating in virtual reality treatments or other exposure therapies, you should contact Dr. Josh Spitalnick, Director of Clinical Services at Virtually Better, at 404.634.3400 x 223.

Virtually Better regularly collects information about the progress of therapy. I understand that I may be asked to fill out questionnaires at different times throughout therapy. I give my permission for such information to be used for research purposes, with the understanding that such information will not contain my name or other identifying information.

Please read the following information carefully and discuss any questions or concerns with your therapist:

- ❖ Sessions are 50 minutes, including time spent paying fees, scheduling future appointments, etc.
- ❖ The fee for each session is \$160.00.
- ❖ Fees are payable at the beginning or end of each session. You may pay in advance, but you may not miss payments unless this is specifically negotiated ahead of time.
- ❖ We do not submit claims directly to insurance companies, but will gladly provide you with a statement of services rendered for you to file with your insurance company if you so choose.
- ❖ You will be required to pay full fee for sessions that are not canceled or rescheduled 24 hours in advance. Note that most insurance companies will not reimburse you for missed sessions.
- ❖ I understand that after-hours services and emergency services are not available at Virtually Better. In the event of an emergency, I will contact local emergency services.

I understand that information about my treatment at Virtually Better will be kept confidential in accordance with the Ethical Principles of the American Psychological Association and the Laws of Georgia. These guidelines require exception to confidentiality under the following circumstances: a) when a client is a serious danger to him or herself or to another; b) when the therapist is informed of physical or sexual abuse to a minor or elderly individual; c) when a judge orders the release of information to a Court of Law; and d) when the client consents to the release of information to a third party.

I understand that if I choose to seek reimbursement for the costs of this treatment from an insurer, my therapist may be required to provide information about my treatment to the insurance company. By initialing below, I give my expressed permission for Virtually Better to disclose information to my insurance provider and those who they deem appropriate.

Client - initial

Date

My therapist has answered all my questions about treatment at Virtually Better to my satisfaction. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best done in consultation with my therapist.

I have been given a copy of this consent.

Printed Name of Client

Client Signature (or parent or guardian, if minor)

Date

Psychologist (Witness)

Date