Telepsychiatry Consent Form

Telepsychiatry is the delivery of psychiatric services using interactive video conferencing that enables a psychiatrist or his associates at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct patient/psychiatrist visit. Telepsychiatry will allow me to receive medical care without the need to visit the office and travel long distance.

The interactive electronic systems used in telepsychiatry are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Our practice currently uses Doxy, a HIPAA compliant telehealth platform. You can review the security features of Doxy at https://doxy.me/en/patients/. We may use the landline telephone for audio to enhance the security of the information being discussed.

During the telepsychiatry consultation

- Details of my medical history, current medications, and results of medical tests will be discussed.
- Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
- At times students may be present during the session. I will be informed about who is present in the office.

The potential benefits of telepsychiatry:

- Increased accessibility to psychiatric care
- Patient convenience

The potential risks of telepsychiatry include, but are not limited to:

- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- Information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by the provider
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry: Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I understand that the Doxy technology used Beaches Behavioral is encrypted to prevent the unauthorized access to my private medical information.
- In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g.

face-to-face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry and that despite my efforts and the efforts of my psychiatrist, my condition may not be improved, and in some cases may even get worse.

- I understand that I have a right to access my medical information and copies of medical records in accordance with Florida Law.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Florida also apply to telepsychiatry

Patient Responsibilities:

I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I understand that I must be a resident of the State of Florida to be eligible for telepsychiatry services from Beaches Behavioral.

I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.

I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to- face visit, or a second telepsychiatry visit.

I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.

I understand that it is my responsibility to keep my contact information (phone number, email, address) updated to ensure I receive communications regarding my care.

Patient Consent to The Use of Telepsychiatry:

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Beaches Behavioral and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Beaches Behavioral, to use telemedicine in the course of my diagnosis and treatment. If for any reason/s, telepsychiatry will not work for my treatment, my provider will talk to me about my choices. I understand that I will be responsible for any charges not covered by my health insurance.

_____ _____

Patient Name Date

_____

Signature