Telepsychiatry Treatment Consent Form

Introduction:
Telepsychiatry is the provision of non-face-to-face psychiatric services using distance communication technologies such as telephone, e-mail, chat and interactive video conferencing services. These services enable your healthcare provider and/or her associates to provide treatment to their patients from a distant location. These telepsychiatry consultations will not be the same as an in-person psychiatry-patient consultation.

During the telepsychiatry consultation:

a. Details of my medical history, current medications, and results of medical tests may be discussed.
b. Non-medical personnel may be present to assist in the operation of video conferencing equipment, training purposes, or as otherwise needed.
c. You are receiving this treatment in lieu of an in-person visit.

Potential Risks:
The risks associated with telepsychiatry include, but are not limited to:

- Telepsychiatry has its limitations regarding physical examination and information transmitted via video conferencing may not be sufficient to allow for appropriate medical decision making by my healthcare provider.
- My healthcare provider may not be able to provide the type of treatment needed using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failure of the equipment.
- Security protocols can fail, causing a breach of privacy of my protected health information ("PHI").

Patient's Rights:
- The laws that protect the privacy and confidentiality of my PHI also apply to telepsychiatry services.
- I have the right to withhold or withdraw my consent to the use of these telepsychiatry services during the course of my treatment at any time. I understand that my withdrawal of consent will not affect any future treatment.
- I have the right to ask questions and receive an explanation regarding my diagnosis, treatment, medications, and any of the healthcare provider's instructions.
- I have the right to receive an explanation of costs for treatment.
- I have the right to file a complaint against House of Wellness and my healthcare provider with the Florida Department of Health. Their contact information will be provided upon request.

Responsibilities:
- I will follow of my healthcare provider's instructions concerning medications, follow-up visits, and other essential components of my treatment and will notify my healthcare provider if the instructions cannot be followed or problems develop.

- Neither the client nor healthcare provider may use any type of video recording device during any portion of our telepsychiatry sessions without first obtaining written consent from the other party.
- I will inform my healthcare provider if any other person can hear or see any portion of our session as soon as it is reasonably discoverable. It is my responsibility to create a safe and comfortable environment and to ensure that I am in a private area where the session can't be easily overhead by passersby.
- My healthcare provider will inform me if any other person can hear or see any portion of our session as soon as it is reasonably discoverable. It is agreed that these individuals will maintain confidentiality of the information obtained. I understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and (3) terminate the consultation at any time.
- I understand that I, not House of Wellness and/or its associates, am responsible for the configuration of any electronic equipment used on my computer for our telepsychiatry sessions. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I will provide my healthcare provider with the names and contact information of a local psychiatric receiving hospital, that can be contacted to provide me with treatment should an emergency arise unexpectedly. In the event of an emergency, my healthcare provider has the authority under Florida and Federal law[1] to break our confidentiality agreement to the extent necessary, to provide life-saving information or to reduce the risk of harm to myself or to a third party.

Technology Failure:

I do understand that in the event of a technology failure during a phone or visual telecommunication session immediate steps will be taken by House of Wellness and/or its staff to reconnect. Contact via email is the first backup step to failed phone and visual telecommunication reconnection. House of Wellness and/or its staff will repeatedly attempt to use these methods to contact me through the remaining session time (and I will do the same, as well). The compromised appointment will be rescheduled and, unless other arrangements are made, will be billed at the full rate.

Acknowledgements:

1. I understand that I am voluntarily engaging in a telepsychiatry consultation with House of Wellness.
2. I understand that telepsychiatry services offered through House of Wellness is not an Emergency Service and in the event of an emergency I will call 911.
3. I understand that some of the video conferencing services and technology used by House of Wellness, LLC ("House of Wellness") and its providers may use encryption technology to prevent the unauthorized access to my PHI.
4. I understand that my healthcare provider and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. I understand that in order to maintain my privacy I will not share telehealth login information or video conferencing links with anyone unauthorized to attend the appointment.
6. I understand that portions of my physical examination, such as physical tests, examination of body parts, and vital signs may be conducted by individuals at my location at the direction of my healthcare provider, or not performed at all.

[1] The Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

7. I understand that my provider has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my treatment.
8. I agree to assist House of Wellness in obtaining approvals for payments for treatment.

Miscellaneous:

- I understand that I must provide 24-hour notice of cancellation of our telepsychiatry session in accordance with the House of Wellness policy.
- All paperwork must be completed, signed and returned to our office a minimum of 24 hours prior to the session along with a copy of a valid form of photo identification.
- If you have any urgent concerns, please seek medical attention immediately.
- I agree that neither my healthcare provider nor the House of Wellness shall be responsible for my inability to contact House of Wellness and my healthcare provider except as such failure may have been caused by the negligence or intentional misconduct of my healthcare provider or the House of Wellness.
- This document does not replace other agreements, contracts, or documentation of informed consent.

Patient Consent for the Use of Telepsychiatry:

I _____ have read and understand the information provided above regarding telepsychiatry, have discussed any concerns with House of Wellness and its healthcare providers, and any and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my treatment and authorize my healthcare provider to use telepsychiatry in the course of my diagnosis and treatment. I consent to the use of HIPAA compliant interactive video conference software for my distance counseling. By signing this consent form you agree that you have received a copy of this consent form.

Patient Signature: _____ **Date**: _____

Name: _____

Email address: _____

Phone: _____

Psychiatric Receiving Hospital:

Name: _____

Address: _____

Phone: _____