TELEHEALTH CONSENT FORM

Tele-health is a form of two-way, real time, video and audio conferencing, which provides services to clients and their families who are unable to travel to a clinic or who live in rural areas where psychiatric service is hard to find. Via telepsychiatry, we provide a wide array of services including but not limited to diagnosis and assessment, medication management, individual and couples therapy and more. Services are provided by qualified and licensed providers and it does not require transportation of the patient to the office. To qualify for telehealth services the patient must be an established patient and have consented to telehealth services. Electronic systems used is a high quality, real-time (synchronous) audiovisual link using HIPAA-compliant telehealth platform to protect the confidentiality of patient identification, however as with any other technology devices, we can't guarantee confidentiality.

Expected Benefits:

- Improved access to high quality care and continuity of care
- Enables patient education and compliance
- More efficient medical evaluation and management
- Allows for timely and convenient service
- Obtaining expertise of a distant specialist
- Cost efficient

Eligibility to Participate in Telehealth:

- Must be 18 years or older to participate in telehealth or have parent present
- Must provide valid state issued photo ID at the time of each session
- Must be in the state of Maryland during time of session
- Must have access to a computer or smart device that will allow both audio and video connection that is of sufficient quality
- Must be in a private or isolated setting during time of session
- Must always maintain a valid phone number in records

By signing this form, I understand the following:
Please **initial** each numbered line, indicating your understanding and consent.

_____1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

_____2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth through the course of my care at any time, without affecting my right to future care or treatment.

_____3. I understand that I have the right to inspect all information obtained and recorded through the course of a telehealth interaction and may receive copies of this information for a reasonable fee.

_____4. I understand that a variety of alternative methods of mental health and medical care may be available to me, and that I may choose one or more of these at any time.

_____5. I understand that telehealth may involve electronic communication of my personal mental health and medical information to other mental health and medical practitioners who may be located, in other areas, including out of state.

_____6. I understand that it is my duty to inform my clinician, nurse practitioner and or psychiatrist of electronic interactions regarding my care that I may have with other healthcare providers.

_____7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

_____8. I understand that Telehealth uses a high quality, real-time audiovisual link using HIPAA compliant platform. If there is any disruption in the connection, clinician nurse practitioner and or psychiatrist will try to re- establish the connection as soon as possible, if we are unable to do so, we will call you immediately on your phone number in our files.

_____9. I understand that in case of an emergency, my clinician, nurse practitioner and or psychiatrist will call 911 to get me appropriate care, as my clinician, nurse practitioner and or psychiatrist is not physically present with me, my clinician has limitations to assist me.

_____10. I understand that my clinician, nurse practitioner and or psychiatrist has the right to use his/her own judgement to determine if I am suitable and appropriate client for using Telehealth.

_____11. I understand that my clinician, nurse practitioner and or psychiatrist may request me to be seen in the office as and when needed and I will comply with these requests.

_____12. I understand that the first visit will be a face to face visit in the office with my psychiatrist

_____13. I understand and agree that telehealth session will not be used for emergency visits or crisis intervention. During emergency situations I agree to follow up in the office for face to face visit

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care, including but not limited to diagnosis and treatment plan.

Patient Name: _____ DOB: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____