

PSYCHIATRIC ASSOCIATES OF ATLANTA

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Patient Information and Informed Consent for Telepsychiatry Service

Telepsychiatry is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

- A computer and a webcam with microphone to video conference using a HIPAA compliant online company specializing in telemedicine.

Potential Benefits

- Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the doctor and the doctor makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the doctor will call the patient back at the phone number provided on this form.
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
- The provider may not be able to provide treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.

- A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during the course of my care at any time.
- I understand that all the rules and regulations which apply to the practice of medicine in the state of Georgia also apply to telepsychiatry.
- I understand that the provider will not record any of our telepsychiatry sessions without written consent.
- I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.
- I understand that the company that the doctor has chosen to conduct the online appointment (see Guidelines) is an independent company specializing in HIPAA compliant telemedicine. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.
- I will not record any telepsychiatry sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and I agree to revert to a telephone voice session utilizing the indicated backup telephone number provided below should a video connection not function properly. If I am experiencing any technical difficulties, Psychiatric Associates of Atlanta encourages me to call/contact the company chosen for online appointments for technical support.

- I have read and understand that all of the clinic policies of Psychiatric Associates of Atlanta apply to all telemedicine as well as all in-person visits.
- I understand that I agree to be seen face to face at least once a year to maintain therapeutic services and a provider/patient relationship.
- I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in Psychiatric Associates of Atlanta's office, face to face, prior to commencing telepsychiatry treatment.
- I consent to paying fees that are the same as an in-office visit for the type and length of service provided, by using a credit card number phoned in to the Psychiatric Associates of Atlanta office or by a check mailed to Psychiatric Associates of Atlanta at the time of service.
- I understand that a telepsychiatry appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment or cancel it less than one full business day in advance, there will be a charge for a missed appointment for the time my practitioner has reserved for the scheduled appointment.

Data and Signature Page

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider and all 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 the provider to use telepsychiatry in the course of my diagnosis and treatment.

Patient Name: First: _____ MI: _____ Last: _____

Date of Birth: ____/____/____

Address: _____, City: _____, State: _____

Zip: _____

Patient's preferred email address: _____

Patient backup telephone contact: (____)____-____

Alternate contact: (____)____-____

Indicate the Telemedicine Provider with whom you will have your appointment under this agreement/consent: _____

Signature: _____ Date: ____/____/____

Patient () or Guardian ()