Informed Consent for Telepsychiatry Services

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 electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

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:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision making by the psychiatrist.
- The provider may not be able to provide medical 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.
- 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 Dr. Mateo is encrypted to prevent the unauthorized access to my private medical information.
- At any time during my care, I have the right to withhold or withdraw my consent for the use of telepsychiatry. I understand that my withdrawal of consent will not affect any future care or treatment.
- 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 Dr. Mateo will not record any of our telepsychiatry sessions without my written consent.
- I understand that Dr. Mateo will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

My Responsibilities

- I will not record any telepsychiatry sessions without written consent from Dr. Mateo. I will inform Dr. Mateo if any other person can hear or see any part or our session before the session begins.
- I understand that I, not Dr. Mateo, am responsible to provider 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 agree to revert to a telephone voice session utilizing the indicated backup telephone number provided below should a video connection not function properly.
- I have read and understand that all of Dr. Mateo’s office policies apply to all telemedicine as well as in-person visits.

- I agree that a telemedicine appointment must be done in a quiet private space from the patient's home.
- I agree to be seen face to face at least twice a year to maintain therapeutic services and a provider/patient relationship.
- I understand that I must establish a medical therapeutic relationship with Dr. Mateo 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. These fees can be paid by credit card via Square, phoned to Dr. Mateo's assistant or a check mailed to Dr. Mateo's office within a week of the time of service.
- **I understand that a telepsychiatry appointment is scheduled the same as an office appointment and should I not be available for the appointment or cancel it less that one full business day in advance, it will be charged as a missed appointment for the time Dr. Mateo has reserved for a scheduled appointment.**

I have read and understand the information presented above. I have had the opportunity to discuss this information with Dr. Mateo 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 telemedicine during diagnosis and treatment.

Patient Name First: _____MI: _____Last: _____

Date of Birth: _____/_____/_____

Patient email: _____

Telephone #: (____) _____-_____

Alternate Telephone #: (_____) _____ -_____

_____

Signature (patient signature or authorized guardian if patient is under 18 years old)

Patient ( ) or Guardian ( )