Telepsychiatry Informed Consent

Patient Name: _____ Date of Birth:_____
Location of Patient: _____

Introduction

Telepsychiatry is a form of telemedicine that allows patients to access psychiatric services using audio-video interfacing such as videoconferencing. Your primary care provider (PCP) has referred you for an assessment. The purpose of this consultation is to assist your PCP manage your mental health needs. Information provided during your visit will be part of your electronic health record and will be shared with your immediate healthcare team. This will allow your integrated healthcare team to provide the best comprehensive care.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

My Rights:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry. Exceptions to this include emergent situations or cases where child, elderly or disabled neglect or abuse is occurring.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in 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 in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
5. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.
6. I understand that all the rules and regulations which apply to the practice of medicine in the state of Texas also apply to telepsychiatry.

My Responsibilities:

1. I must be physically present in Texas to receive telepsychiatry services.
2. I may not record visits without the consent of the telepsychiatry provider.
3. I will inform the telepsychiatry provider if the telehealth equipment is not functioning adequately or if I am not satisfied with the privacy of the setting where the visit will occur.

4. I understand I am responsible for telling the psychiatric provider important information about my health, including past illnesses, hospitalizations, medications (including over-the-counter, herbal, and street drugs), and pain to help facilitate an accurate assessment of my condition and treatment needs.
5. I understand that my primary care provider is managing my condition in consultation with the telepsychiatry services.
    a. Any concerns or questions about my care, such as medication side effects, should be addressed first with my primary care provider.
    b. If needed, my primary care provider will ask for subsequent telepsychiatry consultation or refer me to other resources for care.
    c. If I am having an emergency such as a severe side effect to a medication, suicidal thoughts or violent thoughts, I will call 911 or go to the nearest emergency room.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with the psychiatric provider, 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.

I hereby authorize Frontera Healthcare Network to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:*_____

*If authorized signer, relationship to patient:*_____

*Witness:*_____ *Date:*_____