
Patient Name_____ Date of Birth_____

1. I understand that my healthcare provider wishes to engage in psychiatric treatment via telemedicine,
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation that will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may be present during the consultation other than my healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus have the right to request the following: (1)omit specific details of my psychiatric history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and/ or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me , and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals in my location at the direction of the consulting healthcare provider.
6. I understand that billing will occur from my practitioner.
7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed in a language in which I understand.

   By signing this form, I certify:

   - That I have read or had this form read and/or had this form explained to me.
   - That I fully understand its contents including risks and benefits of the procedure(s).
   - That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

_____ Date_____

Patient/Guardian signature

_____

Printed name

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