Telehealth Informed Consent

Patient Name: _____

Patient Date of Birth: _____

Telehealth is the delivery of psychiatric and other mental health and medical services using interactive audio and visual electronic systems where the clinician and the patient are not in the same physical location. Carissimi Mental Health & Wellness PLLC allows its clinicians to perform telehealth when clinically appropriate using HIPAA-compliant platforms including Zoom and/or Doxy. The interactive electronic systems used by these platforms incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry Benefits:

- Increased accessibility to care

-Patient convenience

-Obtaining expertise of a distant clinician

Potential Telepsychiatry Risks:

-Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my clinician.

-Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.

-Security protocols can fail, causing a breach of privacy of my confidential medical information.

-In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telehealth sessions when I schedule follow-up appointments. If my clinician agrees, I will be scheduled for a telehealth

session, and I will be sent an internet link with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

My Rights:

(1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telehealth.

(2) I understand that all the state rules and regulations which apply to in-person sessions also apply to telehealth sessions

(3) I understand that my clinician has the right to withhold or withdraw their consent for the use of telehealth at any time during the course of my care.

(4) I understand that I have the right to withhold or withdraw my consent for the use of telehealth at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my clinician unless it becomes logistically impossible to continue care. Referrals will be made if that is the case.

My Responsibilities:

(1) I will inform my psychiatrist as soon as my session begins of my physical location and will not unexpectedly join from states where my clinician is not licensed. I understand the clinician may need to terminate the session should I join from a location where they are not licensed. Exceptions are made in the case of emergency or crisis . I will also join from a safe and private location and not while driving or operating heavy machinery.

(2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have a working camera and audio input so that my clinician can see and hear me in real time.

(3) I will not record any telepsychiatry sessions without written consent from Carissimi Mental Health & Wellness PLLC, and I understand that my clinician will not record any of our telehealth sessions without my written consent.

(4) I will inform my clinician as soon as my session begins if any other person can hear or see any part of our session.

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(5) If I lose my connection during a session, I will immediately attempt to log back into the "waiting room." (6) If the audio I am receiving during a telehealth session is not complete and clear, I will attempt to let my clinician know or contact Carissimi Mental Health & Wellness PLLC, to schedule a new appointment.

Signature:_____
Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

Date:_____