



Renaissance Behavioral M E D I C I N E

TELEPSYCHIATRY PATIENT CONSENT FORM

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:

- Reduced wait time to receive psychiatric care.
- Patient convenience
- Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- 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 judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Renaissance Behavioral Medicine utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

- Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:

- The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

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- I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, that:
 - the transmission of my medical information could be disrupted or distorted by technical failures;
 - the transmission of my medical information could be interrupted by unauthorized persons;
 - and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry and that despite my efforts and the efforts of my psychiatrist, my condition may not be improved, and in some cases may even get worse.
- I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with California Law

Patient's Responsibilities

- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
 - I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.



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Patient Consent To The Use of Telepsychiatry:

I hereby consent to engaging in telepsychiatry with RENAISSANCE BEHAVIORAL MEDICINE as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understood the information provided above regarding telepsychiatry.

Signature
Patient's Name:
Date Signed:

Or, if patient is below 18 years old:

Patient's Name:

Signature
Legal Guardian/Representative:
Date Signed: