TELEPSYCHIATRIC SERVICE AND RELATED SERVICES AGREEMENT

Date:_____

Patient Name: _____ **DOB:** _____

Patient information and Informed Consent for Telepsychiatry Services

The Costello Clinic has partnered with Neurocare Group and is now rebranding as Dallas Neurocare Therapy.

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

Requirements:

*A computer and a webcam with a microphone to video conference using a HIPAA compliant online company adherent to telemedicine practice principles.

Potential Benefits:

*Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away to college or an extended stay away from home or having a physical limitation preventing travel to our office or when arranged and agreed to in advance with the patient's provider.

Potential Risks:

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 the following:

*Therapy conducted online is technical in nature and problems may occasionally occur with connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with availability or connectivity by a 3rd party are outside the control of the physician or clinical provider. There is no guarantee that services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via video conferencing, then the physician or clinical provider will call the patient back at the phone number designated by the patient.

*Information transmitted may not be sufficient (that is, poor resolution of video) to allow for appropriate medical decision making by the psychiatrist, clinical provider, designee, or therapist.

*The provider may not be able to provide 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.

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*Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

*Although highly unlikely, security protocols can fail resulting in a breach of privacy of confidential 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 judgement.

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 the provider is encrypted to prevent the unauthorized access to my private medical information.

*I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent for telepsychiatric services will not affect any future care or treatment.

*I understand that the provider has the right to withhold or withdraw this consent for the use of telepsychiatric services during the course of my care at any time.

*I understand that all the rules and regulations which apply to the practice of medicine in my state also apply to telespychiatric services.

*I understand that the provider will not record any of our telepsychiatry sessions without written consent.

*I understand that the provider will not allow any other individual to listen, view, or record my telepsychiatry session without my express written permission.

My Responsibilities:

*I agree to take full responsibility for the security of any communications or treatment information involved with my own computer or equipment and with my own physical location.

*I understand that I am solely responsible for maintaining the strict confidentiality of my user ID, password, or identifying information on my part, and I will not allow another person to use my access information in order to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

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*I understand that the company that the doctor has chosen to conduct the online appointment is an independent company adherent to HIPAA compliant telemedicine principles. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/ contact the company directly and address my concerns with them.

*I will not record any telepsychiatric services or sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.

*I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer or receiving end which is used for telepsychiatric services. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins, and I agree to revert to a telephone voice session utilizing the indicated backup telephone number I will provide and keep up-to-date should a video connection not function properly. If I am experiencing any technical difficulties, I am encouraged to call/contact the provider's company chosen for online appointments for technical support.

*I have read and understand that all of the clinic policies apply to all telemedicine as well as all in-person/ face to face visits.

*I understand that I agree to be seen face to face at least once a year and whenever directed to do so by the provider in order to maintain therapeutic services and a provider/ patient relationship.

*I understand that I must establish a medical therapeutic relationship with my proposed provider, face to face, prior to commencing telepsychiatric services or treatments initially, whenever possible.

*I understand that a telepsychiatry appointment is scheduled the same as an in-office appointment would be, and that should I not be available for the appointment or cancel it less than one full business day in advance, then there will be a charge for a missed appointment for the time my provider has reserved for the scheduled appointment.

*I understand there may be a small telepsychiatric services surcharge payable to the office/ clinic for technical equipment and support services expenses incurred by the provider's clinic. Any fee would be agreed to in advance, in writing, and payable to the clinic prior to delivery of the telepsychiatric services. I understand there is as follows: $ _____ fee per telepsychiatric service session surcharge which is my responsibility (not covered by insurance; subject to revision with general clinic fee schedules).

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DATE AND SIGNATURE PAGE

Patient Consent to Use Telepsychiatric Services:

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider or clinic staff 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 telepsychiatry in the course of my diagnosis and treatment.

Patient Name: _____ DOB: _____

Patient's Telephone Contact: _____

Alternative Telephone Contact: _____

*I have left and will keep updated payment information with clinic staff.

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Signature of Patient OR Guardian (if minor): _____

(Printed Name of Guardian (if patient is a minor): _____

Date of Signature: _____ Time: _____

****

Signature of Staff Witness: _____

Printed Name of Staff Witness: _____

Date of Staff Signature: _____ Time: _____