INFORMED CONSENT TO TELEPSYCHIATRY SERVICES

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Introduction

Telepsychiatry is the use of interactive video conferencing software for the delivery of psychiatric services.

Columbia Associates in Psychiatry, P.C. ("Columbia Associates") offers patients the option of participating in telepsychiatry (the "Services") as a convenience to patients and in hopes of improving access to psychiatric care by enabling patients to receive treatment from the comfort of their home. The technical nature of telepsychiatry involves potential risks as well, including those related to interruption in care, delays in medical evaluation, and breaches of security protocols and/or confidential patient information.

Third Party Vendor

Columbia Associates will be using video conferencing software from a third party vendor (the "Vendor") to deliver the Services. While the software incorporates network and security protocols to protect the confidentiality of patient information, Columbia Associates itself does not control the effectiveness of these security measures.

To participate in the Services, patients will need to create an account with the Vendor selected by Columbia Associates and have access to an internet-connected computer with a webcam.

Eligible Patients

Columbia Associates offers the Services as an accommodation to and for the convenience of existing patients. The Services are only available to patients (i) with a pre-existing patient-provider relationship with Columbia Associates and its medical providers; and (ii) during such time that patients are physically present in the Commonwealth of Virginia, which patients will be asked to confirm at the beginning of each session.

Representations

By signing this form, I agree to the following:

a) I am a current patient of Columbia Associates that wishes to receive some services through telepsychiatry, which Columbia Associates offers as an accommodation for the convenience of existing patients.
b) I will only access the Services while physically present in the Commonwealth of Virginia.
c) 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.
d) Columbia Associates has explained to me how the video conferencing technology used for the Services 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.
e) I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of

telepsychiatry that identifies me will be disclosed to other entities (other than the Vendor with which I create an account to access the telepsychiatry services) without my consent.

f) Notwithstanding the foregoing, I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
g) I understand there are potential risks to this technology, including interruptions in care, unauthorized access, and technical difficulties. While the Vendor has entered a Business Associate Agreement agreeing to protect my Protected Health Information ("PHI") in accordance with HIPAA, I understand that the Vendor (and not Columbia Associates) has control and responsibility for protecting my PHI against unauthorized use or disclosure.
h) 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.
i) I have had the alternatives to a telepsychiatry consultation explained to me.
j) 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.
k) I understand I am solely responsible for ensuring access to a webcam enabled computer and software compatible with the Vendor's applicable requirements.

Informed Consent to use Telepsychiatry Services

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my mental health provider or such assistants as may be designated, 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 Columbia Associates and its medical providers to use telepsychiatry in the course of my diagnosis and treatment.

Signature: _____ Date: _____

Name: _____

Relationship (if not patient): _____