Atlanta Area

Family Psychiatry Clinic, PC

Child, Adolescent, Adult and Family Psychiatry

7000 Peachtree Dunwoody Road
Building 16, Suite 100
Atlanta, Georgia 30328-5754

Voice (770) 393-1880
FAX (770) 393-1885
www.AAFPC.net

Patient Information and Informed Consent for Telepsychiatry Service

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 microphone to video conference using Skype (www.skype.com), a free software readily available to all computer users.

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 at college or an extended stay away from home or having a physical limitation preventing travel to our office.

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:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
- The provider may not be able to provide medical 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.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical 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 judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the Skype 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 will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during the course of my care at any time.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Georgia also apply to telepsychiatry.
- I understand that the provider will not record any of our telepsychiatry sessions without my written consent.
- I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

My Responsibilities

- I will not record any telepsychiatry 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 which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and agree to revert to a telephone voice session utilizing the indicated backup telephone number provided below should a video connection not function properly.
- I have read and understand that all clinic policies of the Atlanta Area Family Psychiatry Clinic apply to all telemedicine as well as all in-person visits
- I understand that I agree to be seen face to face at least once a year to maintain therapeutic services and a provider/patient relationship.
- I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in the AAFPC's office face to face prior to commencing telepsychiatry treatment.
- I consent to paying fees that are that same as an in office visits for the type and length of service provided by credit card phoned to AAFPC's secretary or a check mailed to AAFPC at the time of service.
- **I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be and should I not be available for the appointment or cancel it less than one full business day in advance, it will be charged as a missed appointment for the time my practitioner has reserved for a scheduled appointment.**

Data and Signature page

Patient Consent to the Use of Telepsychiatry

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

Patient Name: First: _____ MI: ____ Last: _____

Date of Birth: _____/_____/_____

Address: _____, City: _____, State: _____ ZIP:_____

Patient Skype Name: _____

Patient (Skype) email: _____

Patient backup telephone contact: (_____) _____-_____

Alternate contact: (_____) _____-_____

Indicate the Telemedicine Provider who you will have your appointment with covered under this

agreement/consent: _____

Signature: _____ Date: ___/____/_____

Patient ( ) or Guardian ( )

Patient Signature or authorized person if patient is under 18 years old), relationship _____

or

This consent may be digitally signed by typing in the blanks above and full name and date above and typing "I consent to these terms" on the line below:

Begin Typing Full Name Signature on the next line.

I accept these terms and conditions: "X" _

Send Digitally Signed copy by email to Office@AAFPC.net (note this email address is only to be used to send documents to AAFPC, we do not reply nor respond to messages sent by email) or **FAX** to **(770) 393-1885**