Telepsychiatry Contract and Informed Consent

I (patient): _____

My Provider: _____

Telepsychiatry Contract and Informed Consent:

Telepsychiatry is the delivery of psychiatry (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 (or smart phone) with functional webcam and microphone for video conferencing using a HIPAA compliant service specializing in telemedicine.

Potential Benefits:

- Telepsychiatry eliminates barriers to accessing healthcare and provides alternative means to obtain behavioral health services for patients who may otherwise have limited accessibility or encounter prolonged waiting lists in the community.
- In addition to removing the burden of travel time to a physical medical office as well as the risks and costs associated with transportation, telemental health allows for flexible scheduling.
- Telemental health offers a reduction of stigma by providing private treatment in the comfort of the patient's personal space.
- Telemental health can provide treatment to patients with disabilities and limited mobility without requiring extensive planning for transport.

Potential Risks:

- Telepsychiatry audiovisual equipment may experience technical difficulties.
- While every precaution is taken to secure patient data and maintain confidentiality, the nature of electronic appointments results in additional exposure to security breaches.
- Telepsychiatry may not be suitable for certain illnesses that require higher levels of care.
- Certain illnesses may not be adequately treated by telepsychiatry.
- It is the discretion of the mental health provider regarding continuation of telemental health services.

Medication Prescribing:

- All medications prescribed by the mental health provider will be sent electronically to the pharmacy on file.
- Controlled substances such as stimulants, benzodiazepines, and hypnotics will be prescribed at the provider's discretion. A Discovery Mental Health Services Controlled Substance Contract must be completed by the client and faxed/mailed/delivered to Discovery Mental Health Services prior to controlled substance prescriptions being provided.
- All clients prescribed controlled substances must present in person either at Discovery Mental Health Services or an affiliate lab entity to complete a set of vital signs and urine drug screen prior to prescriptions being sent to the pharmacy.

Required Information at Every Visit:

- Name, location, and telephone number of the patient at the time of session. This is to ensure that your provider is aware of alternative means of treatment should an emergency occur.

Activities Permitting During Telemedicine Services

- Prescription refills will be permitted at the time of the appointment.
- Appointment scheduling can be done outside of the appointment by going online to https://www.discoverymh.com/ or calling our office.

Responsibilities of the Provider:

1. Discovery Mental Health Services reserves the right to assess suitability and appropriateness of telepsychiatry candidates due to the potential limitations of the treatment modality mentioned above.
2. In the event of imminent danger, the provider is legally and ethically bound to report information to authorities, family members, or others, to minimize potential harm.

Responsibilities of the Patient:

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- 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.
- I understand that I must be seen face-to-face at least one time per year.
- I understand that it is my responsibility to verify insurance coverage/eligibility for telepsychiatry treatment.
- I agree to either provide the office with vital signs obtained from a primary care physician's office or appear to Discovery Mental Health Services within one week before or after the scheduled telepsychiatry appointment for vital signs.

For ALL patients:

I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS WITH RESPECT TO TELEMEDICINE:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during 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.
3. I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.
4. I understand that all of the clinic policies of Discovery Mental Health Services apply to all telemedicine visits as well as all in-person visits.
5. I understand that I must pay my co-pay, co-insurance, and applicable fees prior to my telepsychiatry appointment.

Cancellation and Late Policy:

- All appointments must be cancelled twenty-four (24) hours in advance of the scheduled appointment.
- A charge of $35 will be applied to the clients account for lack of or inappropriate notification of a missed appointment.
- Missed appointments are disadvantageous to your provider and Discovery Mental Health Services. Multiple missed/no-show appointments may result in discharge.

I certify that I have read and understand the entirety of this document, titled "Telepsychiatry Contract and Informed Consent." By signing below, I am agreeing with this document, put forward by Discovery Mental Health Services, and I am also authorizing Discovery Mental Health Services to use telepsychiatry for my evaluation and treatment.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____

Signature Print Name

Date: _____ Time: _____ A.M. / P.M.

WITNESS/PROVIDER:

_____ _____

Signature Print Name

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