TELEHEALTH PATIENT CONSENT

Patient Name: _____ **Date of Birth:** _____

INFORMED CONSENT AND PRIVACY FOR TELEMEDICINE
Consent for TELEHEALTH PATIENT CONSENT

1. I **Purpose:** The purpose of this form is to obtain your consent to participate in telehealth for the following service(s):

    - Medication Management
    - Therapy (Counseling)
    - Bridge appointment for Medication
    - Group Therapy
    - Consultation/Second opinion

2. **Telehealth in General:** Telehealth involves the real-time evaluation, diagnosis, consultation on, and treatment of a health care condition using advanced telecommunications technology, including interactive audio & video. Electronic systems used have network and software security protocols in place to protect the confidentiality of patients' information.

3. **Expected Benefits:** Psych Associates of Maryland (the "Practice") offers telehealth services to its patients in order to improve access to health care by enabling a patient to remain at home (or at a remote site) while receiving care from a distance.

4. **Potential Risks:**
    - In the event of interruption or disconnection of the audio/video connection, the continuity or completion of a particular telehealth visit will depend upon whether the information transmitted is sufficient for the patient's condition. If the audio/video connection is inadequate for that purpose or is disconnected, the Practice may require an in-person visit.
    - Your health information will be transmitted electronically by audio and video. In accordance with HIPAA regulations, the Practice has implemented strict privacy and security precautions to protect its patients' health information; however, the security and confidentiality of information transmitted electronically may be compromised by the failure of these security safeguards or illegal or improper tampering.
    - While the Practice has taken reasonable and appropriate efforts to eliminate any confidentiality risks associated with your telehealth appointment, the Practice cannot control your environment or any company you may have with you during the telehealth appointment.

5. **Nature of Telehealth:**
    - During the telehealth appointment, details of your medical history and current condition may be discussed by interactive audio-video technology. The Practice and its providers rely on information provided by you and it is your responsibility to provide information about your medical history, condition, and care that is complete and accurate to the best of your ability. The Practice and its providers' advice, recommendations, and decisions may be based on factors not within their control,

such as incomplete or inaccurate data provided by you or distortions of audio/video during the telehealth visit.

- The Practice has the right to determine if a telehealth appointment is appropriate for your needs and may recommend an in-person appointment.

6. **Medical Records:** All existing State and federal laws regarding the privacy and security of your medical records apply to this telehealth appointment, as detailed in the Practice's Notice of Privacy Practices. In accordance with HIPAA, the Practice will not record or store any video, images, or audio of your telehealth appointment, and by signing below you agree not to record or store any video, images, or audio of your telehealth appointment. Your provider will document the medical information conveyed during the appointment into your medical record the same as if it was an in-person office visit. You have the right to obtain copies of your medical records; any requests to inspect and obtain copies of medical records associated with telehealth will be made in accordance with the Practice's standard policies and procedures.

7. **Payment Agreement.** By signing below, you understand that your insurance will be billed for any telehealth services you receive from the Practice; you may be billed for what your insurance does not cover; and you have been advised to check with your insurance carrier for coverage of telehealth visits. If your insurer does not cover telehealth visits, then you will be responsible for the full fees for telehealth services you receive from the Practice. If you have any questions about your billing, you should contact the Practice's office.

8. **Data and Devices.** The Practice does not warrant that its telehealth services will be compatible with any updates to, or prior versions of, your devices' operating systems. To the extent that your telehealth appointment requires the use of wireless, cellular data, or internet access, you are responsible for securing the necessary data access service. E.g., your mobile phone provider may charge you data access fees in connection with your use of telehealth services. You are solely responsible for all such charges payable to third parties.

9. **Patient Rights:** You may withhold or withdraw your consent to telehealth at any time without affecting your right to future care or treatment. You may contact the Practice at 410-823-6408 for any questions you have related to telehealth services.

10. **Risks, Consequences, and Benefits:** By signing below, you acknowledge that: (i) you have been advised of the potential risks, consequences, and benefits of telehealth; (ii) you have had an opportunity to ask questions about the information presented on this form; and (iii) all your questions have been answered and you understand the information provided above.

My signature below (or other written acknowledgement of my acceptance to the terms above) indicates my consent to participate in a telehealth appointment in connection with the service(s) described above. This consent will be documented in my medical record with the Practice.

Signature: _____Date: _____