QCI Behavioral Health, LLC

for a better life…

Telepsychiatry location:
22196 Three Notch Rd, Suite 304, Lexington Park, MD 20653.
240-427-3554

Telepsychiatry Informed Consent

Patient Name: ____ Date of Birth:_______________

Introduction

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Obtaining expertise of a distant specialist.
- Bringing care closer to a patient's home or work.
- Improving access to mental health care that might not otherwise be available in rural areas.
- Reducing the need for time off work, childcare services, etc. to access appointments far away.
- Reducing potential transportation barriers, such as lack of transportation or the need for long drives.
- Reducing delays in care.
- Providing continuity of care and follow-up.

Possible Risks:

As with any medical practice, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of digital images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the technical equipment.
- In rare instances, a lack of access to complete electronic health records may result in delays in prescribing;

I have read the above benefits and risks of using telepsychiatry technology. By signing this form, I understand the following:

1. 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 which identifies me will be disclosed to researchers or other entities without my consent.

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2. 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.
3. I understand that I have the right to inspect all medical information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
5. 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.

I have read and understand the information provided above regarding telepsychiatry and I hereby give my informed consent for the use of telepsychiatry in my medical care.

By signing below, I, ____ acknowledge, and agree to the terms and information listed above regarding Policy Receipt, Consent to Treatment, Confidentiality, and Use of Information.

____

Signature of Patient (or person acting on behalf of the patient) Date

____

Print Name Relationship to Patient