CONFIDENTIAL

Transcultural Care
Olamide Alabi, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 269 6089
Email: info@transcultural-care.com

TELEPSYCHIATRY INFORMED CONSENT

Patient Name: _____

Location of Patient: _____ 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 confidentiality of patient identification. Imaging data and other protected health information will be protected through measures that safeguard data and ensure the integrity against intentional or unintentional corruption.

Expected Benefits:

1. Improved access to psychiatric care by allowing the patient to remain in the home or office and in a geographical location that serves to be in the patient's best interest to remain due to restrictions in travel.
2. More efficient psychiatric evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are risk associated with telepsychiatry. These risks include but are not limited to:

In rare case, information transmitted may not be sufficient due to poor resolution to allow for appropriate medical decision making by the telepsychiatrist and client.'

Delays in medical evaluation and treatment could occur due to failure of equipment.

In some cases, there may be a lack of access to complete medical records, resulting in adverse drug reactions or allergic reactions as well as other judgmental errors.

Alternative Options:

There are available appointments to have face-to-face encounter visits in an office setting at the physical location of Transcultural Care and when consent is obtained for telepsychiatry, the client is agreeing to obtain telepsychiatric services.

Please initial you have read this page regarding benefits, risks, and alternative options: _____

Telepsychiatric Policies

Transcultural Care: Telepsychiatry Protocol

1. Telepsychiatry cannot provide any provision of medical or psychiatric emergencies. In the case of emergency, patients are encouraged to seek local help or call 911.

2. Patients who receive telepsychiatric services must be seen in person at least once a year.

3. New Patient consultations are done in person and telepsychiatric encounters are for follow up appointments

4. Guidelines generally considered standard for keeping medical records, release of information, and patient confidentially will be applied to telepsychiatry as well.

5. No recording of session is allowed in any circumstances. Patients need to notify the psychiatric provider if another person is present in the session.

6. After initial evaluation or anytime during treatment the psychiatric provider may recommend local psychiatric services, if patients need are judged to be not met through telepsychiatry or if other clinical grounds exist. Every effort will be made to provide local referrals.

7. Medication fills and refills can only be made after the session and is subjected and limited to local pharmacy's guidelines, limitations, and policies. Prescribing controlled medications will have higher level of scrutiny and will be solely at the discretion of the telepsychiatrist based on clinical needs.

8. No shows and late cancellations of less than 24 hours of appointment time will be charged as the same rate as regular in-office appointments.

9. All payments will be made before the sessions.

I agree with the policies outlined above

Patient's Name: ________

Patient's Signature: ______________________________________

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of tele-psychiatry which identified me will be disclosed to researcher and other entities about my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of tele-psychiatry in the course of my care at any time, without affecting my rate and future care or treatment.
3. 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 reasonable fee.
4. I understand that a variety of alternative methods of psychiatric care may be available to me, and I may choose one or more of these at any time.
5. I understand that is is my duty to inform my psychiatric provider of any other healthcare providers in my medical/psychiatric care.
6. I understand that I may expect anticipated benefits from the use of telepsychiatry in my care, but then the results can be guaranteed or assured.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatric provider or such assistance of may be designated, and all of my questions have been answered to my satisfaction. I hereby giving informed consent for the use of telepsychiatry and my medical use.

I hereby authorize _____ to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient: _____ *Date* _____

If Authorized Signer: _____ *Date* _____

Witness: _____ *Date* _____