NEWLIGHT PSYCHIATRIC SERVICES

## Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Skype or Facetime in which the provider and the patient are not at the same location. Telepsychiatry will allow the patient to receive psychiatric care including diagnostic evaluation, medication management, follow ups, psychotherapy services without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

**Your Rights:**

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;

2) I understand that the Skype or Facetime is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of Skype at http://www.skype.com/intl/enus/security/detailed-security/ and Facetime security features at https://www.apple.com/privacy/features/

3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.

4) I understand that Newlight Psychiatric Services has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time;

5) I understand that all rules and regulations which apply to the practice of medicine, psychiatric services and psychotherapy services in the State of Florida also apply to telepsychiatry.

Your Responsibilities:

1) I will not record any telepsychiatry sessions without the prior written consent of Newlight Psychiatric Services or Provider and I understand that Newlight Psychiatric Services or Provider will not record telepsychiatry sessions without my consent;

2) I will inform the provider if any other person can hear or see any part of our session before the session begins. Likewise, provider will inform me if any other person can hear or see any part of the session before the session begins.

3) I understand that I MUST be a resident of Florida to be eligible for telepsychiatry services from Newlight Psychiatric Services.

4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to the provider's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Newlight Psychiatric Services to use telepsychiatry in the course of diagnosis and treatment.

X_____ X_____

Patient or/Legal Guardian Signature Date

X_____

patient or Legal Guardian Name

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