Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using an interactive video conferencing tool, Doxy.me, in which the psychiatric provider and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care 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 Doxy.me 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 Doxy.me at http://www.doxy.me. 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 SBH 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 in the State of Virginia also apply to telepsychiatry.

Your Responsibilities:

1) I will not record any telepsychiatry sessions without the prior written consent of SBH and I understand that SBH will not record telepsychiatry sessions without my consent; 2) I will inform my provider if any other person can hear or see any part of our session before the session begins. Likewise, my 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 need to be in a secure environment and this appointment is treated just like an in-person appointment, with all the same requirements and fees. 4) I understand that all copays/patient cost-share are due before the appointment will starts and it is my responsibility to contact the office with payment. 5) I understand that I MUST be a resident of Virginia to be eligible for telepsychiatry services from SBH. 6) 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 my provider satisfaction before the evaluation. 7) I understand it is MY responsibility to login and be available 5-minutes before my appointment time, failure to due so will result in a No-Show charge to my account -all instructions are available on Seaside Behavioral Health website (seasidebh.com)

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize your provider at SBH to use telepsychiatry in the course of diagnosis and treatment.

____________________	____________________
Patient or Parent/Legal Guardian Signature	Date
____________________	____________________
Patient's name	Relationship to patient

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