CAROLINA COMPLETE
PSYCHIATRY

Consent for Treatment through Telepsychiatry

Carolina Complete Psychiatry offers telepsychiatry services. Telepsychiatry is a form of telemedicine that allows patients to access psychiatric care using audio-video interface without being present in the office. Our practice has chosen to use Doxy.Me. This is similar to Skype or FaceTime, however it isP done through a medical platform so that all information stays private and confidential and complies with HIPAA regulations. Although highly unlikely, security protocols can fail, causing a breath of privacy of confidential medical information, which Carolina Complete Psychiatry is not liable for.

The Consent for Treatment, Patient Rights and Responsibilities, Patient Privacy Practices, and General Office Policies will be maintained for every patient, regardless of appointments being conducted face to face or through telepsychiatry. If you need a copy of these, please ask our staff or visit our website.

If you would like telepsychiatry services, you agree to the following policies and consent:

Office Policies Regarding Telepsychiatry (Please initial each line)

_____ 1. All initial evaluations must be done in person, in the office, unless under extreme/special circumstances. Patients must also be seen in the office at least once (1) every twelve (12) months to continue care. If your provider deems you need face to face service more frequently, this recommendation must be followed. If the appointment is for a minor, the parent or legal guardian will need to be available to speak with the provider as well.

_____ 2. No crisis management will be conducted through telepsychiatry. In the event you are in crisis, you need to go to the nearest emergency department or call 911. If you have urgent needs, you may need to be seen in the office rather than telepsychiatry. Your provider may not be able to provide medical treatment to you using electronic equipment nor provide for or arrange emergency care that you may need. Not all patients are candidates for telepsychiatry appointments. If you have questions regarding this policy, please speak to your provider about this.

_____ 3. Information transmitted may not be sufficient (i.e. poor resolution of video or audio) that may cause hindrance to appropriate medical decision making by your provider. Delays in medical evaluation and treatment may occur due to deficiencies or failure in equipment. Any problems with internet availability or connectivity are outside the control of this practice and Carolina Complete Psychiatry makes no guarantee that such services will be available or work as expected. If absolutely necessary, your appointment may need to be changed over to an audio-only telephone call to the number you have provided on this form.

_____ 4. Telepsychiatry will be done by scheduled appointments only and be charged at the same rate as in office visits. Five to ten minutes prior to your appointment time, our office will contact you by phone. At that time, we will collect payment and send you a link to join a digital waiting room to wait for your provider. If we are unable to get in touch with you by phone to collect payment, your appointment will not take place. Telepsychiatry appointments follow the same No Show/Late Cancellation policy as standard office visits. In the event your appointment is canceled with less than 24 hours notice or you do not show up online for your appointment, you will be charged a $100 ‘late cancellation fee’ or a $160 ‘no show’ fee. You consent to your credit card on file with the office to be charged for this balance.

_____ 5. Under no circumstances are telepsychiatry sessions to be recorded, by the provider or the patient. The sessions are to remain private and the patient is responsible for securing communication to be held in a private location. The patient understands that they may not be operating a moving vehicle or performing any other physical activity that the provider deems as dangerous or distracting to the appointment.

_____ 6. Our office is equipped to provide telepsychiatry services through our internet provider. If you are unsure if your home internet will be able to accommodate this type of service, please feel free to contact our office to set up a test session. It is recommended that your internet have 350 KB/sec, 2.8 MBTS, or 21MB/min. You must use Google Chrome, Safari or Mozilla for Doxy.Me. You are also able to access Doxy.Me through a smartphone, however it is recommended that you are connected to WiFi internet as relying on a cell phone provider's data alone often causes extreme delay in the appointment.

_____ 7. You have the right to to withhold or withdraw consent to the use of telepsychiatry during the course of care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. I understand that the provider has the right to withhold or withdraw care using telepsychiatry during the course of my care should they deem this level of care is not adequate to make informed medical decisions.

_____ 8. Carolina Complete Psychiatry will only provide telepsychiatry to patients who are residents of the state of North Carolina. If you hold residency out of state, telepsychiatry services will only become available if made possible by extreme/extenuating circumstances, such as government order.

Patient Consent to the use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry and office policies. If I had any difficulties understanding this consent, I have asked for clarification. I further understand that if questions arise later, I am able to contact the office at any time. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Carolina Complete Psychiatry to use telemedicine in the course of my diagnosis and treatment.

X_____ Date: _____
(Printed Name of Patient or Parent/Legal Guardian (and relationship if patient is a minor)

X_____
(Signature of Patient or Parent/Legal Guardian)

Should you choose to REFUSE/REVOKE PERMISSION to release the above listed information, sign below:
_____ Date: _____
(Signature of Patient or Parent/Legal Guardian (and relationship if patient is a minor)