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Patient Information and Consent Form for Telepsychiatry

Name:_____ **Date:**_____

Introduction:
Telepsychiatry is the delivery of psychiatric services using interactive video conferencing that enables a psychiatrist or his associates at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct patient/psychiatrist visit. Telepsychiatry will allow me to receive medical care without the need to visit the office and travel long distance.

The interactive electronic systems used in telepsychiatry-Skype- are 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/en-us/security/detailed-security/. We may use the landline telephone for audio to enhance the security of the information being discussed.

During the telepsychiatry consultation-

a. Details of my medical history, current medications, and results of medical tests will be discussed.
b. Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
c. At times students may be present during the session. I will be informed about who is present in the office.

Potential benefits:
- Increased accessibility to psychiatric care
- Patient convenience

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

- Information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by Dr. Kant or his associates.
- Dr. Kant or his associates may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

Alternatives to the use of telepsychiatry:
- Traditional face to face sessions in our office

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My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the Skype technology used by Dr. Kant or his associates is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that Dr. Kant or his associates has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Pennsylvania also apply to telepsychiatry.

My Responsibilities:

- I will not record any telepsychiatry sessions without written consent from Dr. Kant or his associates. I understand that Dr. Kant or his associates will not record any of our telepsychiatry sessions without my written consent.
- I will inform Dr. Kant or his associates if any other person can hear or see any part of our session before the session begins. Dr. Kant or his associates will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Dr. Kant or his associates, am responsible for the configuration of any electronic equipment used on my computer for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be a resident of the state of Pennsylvania or Ohio to be eligible for telepsychiatry services from Dr. Kant or his associates.
- I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to provider satisfaction before the evaluation.

Patient consent for the use of Telepsychiatry:

I _____have read and understand the information provided above regarding telepsychiatry, have discussed it with Dr. Kant or his associates, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Dr. Kant or his associates, to use telemedicine in the course of my diagnosis and treatment. If for any reason/s, telepsychiatry will not work for my treatment, then I will need to come to office for ongoing evaluations and treatments.

Signature of Patient (or person authorized to sign for Patient): _____

If authorized signer, relationship to Patient: _____

Name: _____

Email address_____ Cell telephone #_____

Date:_____

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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient's Name _____Date of Birth_____

Insurance Plan_____ ID#_____

If the insurance plan doesn't pay for the medical services listed below, you may have to pay. The insurance plans do not not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect the insurance plan may not pay for services.

Service/s: (Circle one) ☐Acupuncture☐Reiki ☐Telepsychiatry or other_____
Reason the Insurance Plan May Not Pay: Non-covered service or Other
Estimated cost: _____

WHAT YOU NEED TO DO NOW:
Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the service/s listed above.

NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but the insurance plan cannot require us to do this.

Check only one box. We cannot choose a box for you.

☐ **Option. 1.** I want the medical service/s listed above. You may ask to be paid now, but I also want the insurance company billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if the insurance plan doesn't pay, I am responsible for payment, but I can appeal to the insurance plan by following the directions on the EOB. If the insurance plan does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **Option 2.** I want the service/s listed above, but do not bill the insurance plan. You may ask to be paid now as I am responsible for payment**. I cannot appeal if the insurance plan is not billed.**

☐ **Option 3.** I don't want the service/s listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if the insurance would pay.**

This notice gives only our opinion, not an official insurance plan decision. If you have other questions on this notice on insurance billing, please call your insurance company. Signing below means that you have received and understand this notice. You may also receive a copy.

Signature_____Name _____Date:_____

ABN- Sept 2011

By typing your name into the signature boxes, you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this agreement.

Submit

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Start a web browser and type: http://www.skype.com/

Select “Join Skype”

Select “Create an account and sign in”

Follow prompts to create an account and download software.

Select Contact and add a new contact: “Visitdrkant”