NeuroPsychiatry Center - Ravi Kant, MD, P.C.

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Patient Information and Consent Form for Telehealth

Name: ______________________________ **Date of Birth: ____________________**

Introduction:
Telehealth is the delivery of medical or mental health services using interactive video conferencing or a telephone call (when permitted), that enables a provider at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct an in office visit. Telehealth will allow me to receive medical care without the need to visit the office and travel long distance.

I understand that my insurance may not cover telehealth services. If my insurance does not cover telehealth services, I agree that I will be responsible for self-pay charges for the visit. I am aware that during my telehealth appointment, it is important to be in a private location for the duration of the appointment. I am aware that the telehealth sessions will not be recorded. In the event of a transmission failure, I am aware of the contingency plan. I am aware that I can refuse services via telehealth and that such refusal will not be used as a basis to limit the access to other available services. Alternatives to telehealth services may possibly cause delays in service/s due to scheduling issues, need to travel, and/or risks associated with not having the services provided by telehealth.

The interactive electronic systems used in telehealth 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. Our practice currently uses Doxy, a HIPAA compliant telehealth platform. You can review the security features of Doxy at https://doxy.me/en/patients/ We may use the landline telephone for audio to enhance the security of the information being discussed.

During the telehealth 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 telehealth. 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 telehealth session may result in errors in medical judgment.

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

My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth.
- **I understand that the Doxy 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 telehealth 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 approval for the use of telehealth 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 telehealth services.

My Responsibilities:

- I will not record any telehealth sessions without written consent from Dr. Kant or his associates. I understand that Dr. Kant or his associates will not record any of our telehealth 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 telehealth. 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 to be eligible for telehealth services from Dr. Kant or his associates.**
- I understand that my initial evaluation may not be done by telehealth except in special circumstances under which I will be required to verify my identity to provider satisfaction before the evaluation.

Doxy Instructions:

1. **Five to ten minutes prior to your appointment, please click on the appropriate link for your provider's Doxy account in the telehealth section of our website**

2. **Type in your first and last name and click "check in"**

3. **Your provider will be with you shortly. Please make sure your microphone is unmuted and your webcam is turned on**

I have read and understand the information provided above regarding telehealth, I 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 telehealth in my medical care and authorize Dr. Kant or his associates, to use telemedicine in the course of my evaluation, diagnosis and treatment. If for any reason/s, telehealth will not work for my treatment, then I will need to come to office for ongoing evaluations and treatments.

Patient Signature ______________________________ **Date** ____________

(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Responsible Party Signature ______________________________ **Date** ____________

(Parent/Guardian/Legal Representative)

Print Name ______________________________**Relationship to Patient** ____________

(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness ________________ Name ______________ Date ______________