PSYCHOTHERAPY ASSOCIATES: TELE-PSYCHIATRY SERVICES CONSENT FORM

CLIENT Name:_____

Introduction: Tele-psychiatry is the delivery of psychiatric services using the interactive video conferencing that enables a psychiatrist/psychiatric NP at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct patient/psychiatrist visit. Tele-psychiatry will allow me to receive medical care without the need to visit the office and travel long distances. **SKYPE** is the current method used in tele-psychiatry.

During Tele-psychiatry consultation:

- Details of the medical history, current medications, and results of medical tests will be discussed
- Non-medical personnel may be present to assist in the operation of the conferencing as needed
- Students may be present during the session

Potential Benefits:

- Increased accessibility to psychiatric care and patient convenience

Potential Risks:

- Information may not be sufficient for resolution of the psychiatric needs of the client
- Provider may not be able to assist with emergency care as needed
- Delays in medical treatment may occur due to distance and impediments
- ***Security breaches are possible and SKYPE is not secure***
- Provider can make an error in medical judgement in tele-psychiatry more often than face to face services.

Please review the rights and responsibilities of the service agreement (attached) **Addendum to Service Agreement:**

- Client is to submit payment prior to the Tele-psychiatry appointment of $85 for medication management (15-20 min) (credit cards are accepted)
- Client will not record the tele-psychiatry session without written consent from the Provider at Psychotherapy Associates

Patient Consent for the use of Tele-psychiatry: *I have read and understand the information provided above regarding tele-psychiatry. I hereby give consent for Tele-psychiatry with my provider at Psychotherapy Associates, Inc.* ***If Tele-psychiatry is inadequate for my treatment, I will need to come to the office for ongoing treatment or seek appropriate services in my area.***

Client signature_____Date_____

Provider:_____

SKYPE address_____

Cell phone_____