Atlanta Psychiatric Medicine

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Ph: (770) 837-9666 Fax: (770) 837-9710

I hereby authorize Atlanta Psychiatric Medicine, Inc. (APM). to provide (Circle one) me or my dependent:

Name: _____

DOB: _____

Address: _____

_____

Pharmacy Name: _____

Address: _____

_____

CONSENT FOR TELE-PSYCHIATRY

Introduction

Tele-psychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. The interactive electronic system used in Tele-psychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

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 Tele-psychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision-making by your provider.
- Your provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you 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 confidential health information.
• A lack of access to all the information that might be available in a face to face visit, but not in a Tele-Psychiatry session, may result in errors in judgment.

Alternatives to the Use of Tele-psychiatry

• Traditional face-to-face sessions in your provider's office.

Patient's Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-psychiatry.
• I have the right to withhold or withdraw my consent to the use of Tele-psychiatry 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 have the right to inspect all medical information that includes the Tele-psychiatry visit. I may obtain copies of this medical record information for a reasonable fee.
• I understand that my provider 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 laws that protect the privacy and confidentiality of medical information also apply to Tele-psychiatry.
• I understand that all the rules and regulations that apply to the provision of healthcare services in the State of Georgia also apply to Tele-psychiatry.

Patient's Responsibilities

• I will not record any Tele-psychiatry sessions without written consent from my provider. I understand that my provider will not record any of our Tele-psychiatry session without my written consent.
• I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider 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 my provider, am responsible for the configuration of an electronic equipment used on my computer which is used for Tele-psychiatry. 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 Georgia to be eligible for Telepsychiatry services from my provider.
• I understand that my initial evaluation will not be done Tele-psychiatry except in special circumstances under which I will be required to verify my identity.

Authorization of release of information to other healthcare providers

I hereby authorized APM Inc. to release and obtain information from other professionals who might have provided services for me. I understand that the nature of this communication is solely for the purpose of continuity of my care. This is only to verify therapeutic modalities and their efficacy rather than disclosure of specific issues during the treatment process.

Fee Structure-Following charges are not covered by your insurance and payment in full is required prior or at the time services are rendered.

Services	**Fee**
Copay	Variable
CPT test	$150.00
No show or cancellation without 24 hours prior notice	$30.00
FMLA/STD	$75.00
Paperwork/Letters	$25.00 to $100.00
Returned checks	$25.00
Homebound	$30.00
Urine Drug Screening	$25.00
Medical records	$50.00

Patient Consent to the Use of Tele-psychiatry

I have read and understood the information provided above regarding Tele-psychiatry. I have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Tele-psychiatry in my health care and authorize my provider to use Telepsychiatry in the course of my diagnosis and treatment.

Patient Name: _____

Patient Date of Birth : _____

Note: Parent/Guardian signature required if patient is under eighteen

Patient/Parent/Guardian Signature: _____

Date: _____