Your Family Psychiatrist

TELEPSYCHIATRY INFORMED CONSENT

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location. Your Family Psychiatrist, PLLC allows its psychiatrists to perform telepsychiatry after the initial face-to-face evaluation, and between annual face-to-face re-evaluations, but only through the telemedicine service provider Doxy.me, LLC. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry Benefits:

- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Telepsychiatry Risks:

- Information transmitted may not be sufficient (*e.g.*, poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist.
- Delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telepsychiatry sessions when I schedule follow-up appointments. If my psychiatrist agrees, I will be scheduled for a telepsychiatry session, and I will be sent an internet link (to http://Doxy.me) with instructions to log into the "waiting room" immediately prior to my scheduled appointment.

My Rights:

(1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
(2) I understand that all the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry.
(3) I understand that my psychiatrist has the right to withhold or withdraw his consent for the use of telepsychiatry at any time during the course of my care.
(4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my psychiatrist.

My Responsibilities:

(1) I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry, and my psychiatrist can send prescriptions for medications only to Texas pharmacies or addresses. I will inform my psychiatrist as soon as my session begins of my physical location.
(2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input so that my psychiatrist can see and hear me in real time.
(3) I will not record any telepsychiatry sessions without written consent from Your Family Psychiatrist, PLLC, and I understand that my psychiatrist will not record any of our telepsychiatry sessions without my written consent.
(4) I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session.
(5) If I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me "waiting room".
(6) If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or telephone Your Family Psychiatrist, PLLC to schedule a new appointment.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize my psychiatrist to use telemedicine in the course of my diagnosis and treatment. I agree to hold Your Family Psychiatrist, PLLC and its psychiatrists harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

_____ _____

Printed name Date

_____ _____

Signature of patient (or parent, legal guardian, or conservator) (Relationship to patient)