



CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my psychiatrist wishes me to engage in a telehealth consultation.
2. My psychiatrist explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct patient-psychiatrist visit due to the fact that I will not be in the same room as my psychaitrist.
3. I understand that a telehealth consultation, including both video and phone consultation, has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. Other potential benefits include, but are not limited to improved communication capabilities, reduced costs, improved quality, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.
4. I understand there are potential risks to both video and phone consultations, including interruptions, unauthorized access, and technical difficulties. Other potential risks of phone consultation include, but are not limited to the psychiatrist's inability to make visual observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact, chronological and apparent age, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the psychiatrist not being aware of what she would consider important information, that you may not recognize as significant to present verbally the psychiatrist.
5. I understand that my psychiatrist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I have had a direct conversation with my psychiatrist during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my psychiatrist and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my psychiatrist has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my psychiatrist to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.