



MARIETTA PSYCHIATRY ASSOCIATES PC
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TELEHEALTH CONSENT FORM

Telehealth is the use of electronic information and audio and video communication technologies between a healthcare provider and patient who are not in the same physical location. The information you provide may be used for diagnosis, consultation and treatment, follow-up, education, therapy, care management and self management of your physical and mental health, and may include any combination of the following: (1) health records and test results; (2) image and messaging communication; (3) live two-way audio and video; (4) interactive audio with store and forward (sending of audio and video messages or files); and (5) output information from medical devices.

Expected Benefits:

1. Less, or no, travel time and inconvenience to you.
2. A coordinated care approach with your primary care provider, specialist, or other health providers.
3. Fewer disruptions.

Possible Risks:

1. Delays in evaluation and treatment could happen due to problems or failures of equipment and technology, such as internet connection problems, computer or mobile phone problems, and other technological problems.
2. The clinician may determine that the audio, video or transmitted information is of inadequate quality, which could require rescheduling the telehealth consult or require a face-to-face meeting with your provider.
3. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

4. In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
5. Persons in your home may overhear you or the provider, which could cause privacy concerns.

By accepting with “Informed Consent”, you acknowledge that you understand and agree with the following:

1. I understand I (and my minor child or the patient named, if applicable) must be physically located in the state my clinician is licensed in during my telehealth visit.
2. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately as MARIETTA PSYCHIATRY ASSOCIATES PC providers are not able to connect me directly to any local emergency services.
3. I understand that I will not be prescribed any Drug Enforcement Agency controlled substances via telehealth if not allowed by state law, nor is there any guarantee that I will be given a prescription at all.
4. I understand I will be responsible for any copayments or coinsurances that apply to my telehealth visit.
5. I will not record any telehealth sessions without written consent from my provider. I understand that my provider will not record any of our telehealth sessions without my written consent. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.
6. I will inform my provider if any other person can hear or see any part of our session before the session begins, for example, if a friend or family member is in the room. The provider will also inform me if any other person can hear or see any part of our session before the session begins. I have the right to request the following: (1) leave out details of my medical history or examination that are personally sensitive to me; (2) ask that personnel other than my provider leave the telehealth examination; and/or (3) terminate the consultation at any time.
7. I understand that I am responsible for any electronic equipment used for telehealth, such as my smart phone or computer. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment and my internet connection before my session begins.

8. I understand that MARIETTA PSYCHIATRY ASSOCIATES PC and its providers offer telehealth-based medical services, but that these services do not replace the relationship between my primary care doctor and me. I understand it is up to the MARIETTA PSYCHIATRY ASSOCIATES PC provider to determine whether or not my specific healthcare needs are appropriate for a telehealth encounter
9. I understand that records of my telehealth visits will be documented in my Electronic Health Record (EHR), and acknowledge that my primary care provider and other providers may access these records.
10. I have been given an opportunity to select a provider from MARIETTA PSYCHIATRY ASSOCIATES PC prior to the consult and to ask questions about that provider.
11. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving tests may be conducted at a MARIETTA PSYCHIATRY ASSOCIATES PC facility or other testing facility, at the direction of the MARIETTA PSYCHIATRY ASSOCIATES PC provider (e.g., labs or bloodwork).
12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that MARIETTA PSYCHIATRY ASSOCIATES PC will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners and people responsible for scheduling, insurance, and billing who may be located in other areas, including out of state.
13. I understand that the information disclosed by me during the course of my treatment is confidential, with some exceptions. There are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
14. I understand there is a risk of technical failures during the telehealth encounter beyond the control of MARIETTA PSYCHIATRY ASSOCIATES PC. I agree to hold harmless MARIETTA PSYCHIATRY ASSOCIATES PC for delays in evaluation or for information lost due to such technical failures.
15. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future

care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason.

16. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent

I have read this document carefully, understand the risks and benefits of the telehealth session and have had my questions answered. I hereby give my informed consent (and/or consent on behalf of my minor child or the patient named, if applicable) to participate in a telehealth visit under the terms described herein.