ClearInsight Psychiatry, Inc

Telepsychiatry Informed Consent

Introduction

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interfaces such as videoconferencing. However, it cannot completely replace the traditional face to face evaluation. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. ClearInsight Psychiatry, Inc uses HIPAA approved secured system, WebEx from Cisco.

Expected Benefits:

- Improved access to psychiatric care by enabling a patient to remain in his/her home or office.
- More efficient psychiatric evaluation and management.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of the privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
5. I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits and risks from the use of telepsychiatry in my care, and that no results can be guaranteed or assured.

My Responsibilities:

1. I will not record any telepsychiatry sessions without the prior written consent of Dr. Liang and Dr. Liang's associates.
2. I will inform Dr. Liang and her associates if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Liang will inform me if any other person can hear or see any part of the session before the session begins.
3. I understand that I MUST be a resident of California and physically staying in California when I receive telepsychiatry services from ClearInsight Psychiatry, Inc.
4. I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances.
5. I understand my health insurance may/may not cover this service so it is my responsibility to pay for this service.

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I have been offered a copy of this consent form Yes / No

I hereby authorize ClearInsight Psychiatry, Inc to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:*_____

*Print Your Name:*_____

*If authorized signer, relationship patient:*_____

*Witness:*_____ *Date:*_____