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OUTPATIENT SERVICES CONTRACT: Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Doxy.me, in which the psychiatric provider and the patient are not at the same location. Telepsychiatry will allow the patient to receive services without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

Your Rights: 1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry; 2) I understand that the Doxy.me is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of Doxy.me at https://doxy.me/patients . Doxy.me is a HIPAA compliant platform; 3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time; 4) I understand that Dr. Amos has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time; 5) I understand that all rules and regulations which apply to the practice of medicine in the State of New York also apply to telepsychiatry.

Your Responsibilities: 1) I will not record any telepsychiatry sessions without the prior written consent of Dr. Amos and I understand that Dr. Amos will not record telepsychiatry sessions without my consent; 2) I will inform Dr. Amos if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Amos 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 New York to be eligible for telepsychiatry services from Dr. Amos; 4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to Dr. Amos's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. Amos to use telepsychiatry in the course of diagnosis and treatment.

______________________________	____________________
Patient or Parent/Legal Guardian Signature	Date
______________________________	____________________
Patient's name	Relationship to patient