**The Wellness Tree offers Psychiatry Services via, HIPAA Compliant and Confidential Video Communication.**

This is a form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing. 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.

**Expected Benefits:**

* + Improved access to psychiatric care by enabling a patient to access services at a more convenient location.
  + More efficient psychiatric evaluation and management.
  + Obtaining expertise of a distant specialist, not otherwise available locally.

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of tele-psychiatry. 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 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.

**Please initial in acknowledging that you have read and understand this page**: \_\_\_\_\_\_\_\_\_\_

**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 tele-psychiatry, and that no information obtained in the use of tele-psychiatry 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 tele-psychiatry during 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 during a tele-psychiatry 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 provider of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of tele-psychiatry in my care, but that no results can be guaranteed or assured.
7. I acknowledge my provider is not on site and I will need to maintain accountability with notifying The Wellness Tree seven days prior of needing a refill for any and all medications.

**Patient Consent to the Use of Tele-psychiatry**

I have read and understand the information provided above regarding tele-psychiatry, I have discussed it with my psychiatric provider, 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 tele-psychiatry in my medical care. I hereby authorize The Wellness Tree to use tele-psychiatry in the course of my diagnosis and treatment.

With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my behalf. I also authorize the payment of any governmental or private insurance benefits directly to The Wellness Tree. I acknowledge that I am responsible for all services rendered to me and/or members of my family. I also understand that I am obligated to pay for all services should my insurance eligibility be denied.

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**If authorized signer, relationship to patient: ­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_**