PARK PLACE
BEHAVIORAL HEALTH CARE

PATIENT INFORMATION AND INFORMED CONSENT FOR TELE-HEALTH SERVICES

Tele-health is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

● A computer and a webcam with microphone to video conference using Zoom US (https://.zoom.us), a secure and HIPAA compliant tele-conferencing network.

Potential Benefits

● Tele-health provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of tele-health.
These risks include, but may not be limited to:
● Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
● The provider may not be able to provide medical treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure.
● Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment. Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
● A lack of access to all the information that might be available in a face to face visit, but not in a tele-health session may result in errors in medical judgment.

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My Rights

● I understand that the laws that protect the privacy and confidentiality of medical information also apply to tele-health.
● I understand that the Zoom US technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
● I have the right to withhold or withdraw my consent to the use of tele-health during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
● I understand that the provider has the right to withhold or withdraw his or her consent for the use of tele-health during the course of my care at any time.
● I understand that all of the rules and regulations which apply to the practice of medicine in the state of Florida also apply to tele-health.
● I understand that the provider will not record any of our tele-health sessions without my express written consent.
● I understand that the provider will not allow any other individual to listen to, view, or record my tele-health session without my express written permission.

My Responsibilities

● I have read, and understand, that all clinic policies of Park Place Behavioral Health Care apply to all tele-health as well as all in-person visits.
● I understand that I agree to be seen face to face at least once a year to maintain therapeutic services and a provider/patient relationship.
● I understand that I must establish a medical therapeutic relationship with my proposed tele-health provider at Park Place Behavioral Health Care face-to-face prior to commencing tele-health treatment.
● I consent to paying fees that are the same as in-office visits for the type and length of service at the time of service.
● I understand that a tele-health appointment is scheduled the same as an office appointment would be, and should I not be available for the appointment, or cancel it less than one full business day in advance, it will be charged as a missed appointment for the time my practitioner has reserved for a scheduled appointment .

Patient Consent to the Use of Tele-Health

I have read and understand the information provided in the preceding pages regarding tele-health. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-health in my medical care and authorize the provider to use tele-health in the course of my diagnosis and treatment.

Patient Name: First: _____ MI: ____ Last: _____
Date of Birth: _____/_____/_____
Address: _____, City: _____, State: _____
ZIP _____
Patient email: _____
Patient backup telephone contact: (_____) _____
Alternate contact: (_____) _____
Indicate the Telemedicine Provider who you will have your appointment with covered under this agreement/consent: _____

Signature: _____ Date: _____/_____/_____
Patient ( ) or Guardian ( )

Patient Signature or authorized person if patient is under 18 years old), relationship

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