HARMONIOUS MIND, LLC

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Consent to participate in a TeleMedicine/TelePsychiatry Session

Client Name: _____ Date of Birth: _____

1. I understand that Harmonious Mind, LLC is offering telepsychiatry sessions to me. I understand my participation in telepsychiatry is voluntary and I may refuse participate or decide to stop participation at any time. I understand my refusal to participate or decision to stop participation will be documented in my clinical record. I have been informed of the potential consequences of my refusal to receive telepsychiatry services, including delay of appointment, having to travel some distance, and any risks associated with not having the services provided by telepsychiatry as a more timely option.
2. I understand the telepsychiatry equipment will be shown to me and I will see how it works before I receive any services. I can ask any questions about the equipment and technology to help me further understand telepsychiatry. I understand that this session will not be the same as a direct consumer/psychiatry visit due to the fact that I will not be in the same room as my psychiatrist.
3. I understand all existing confidentiality and privacy policies of HM, the state and HIPAA apply to the telepsychiatry session and records of the sessions. Additionally, I understand the psychiatrist offering telepsychiatry services is licensed and credentialed in Delaware and is bound by existing confidentiality and privacy policies of Harmonious Mind, the state and HIPAA.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand my psychiatrist or I can discontinue the telemedicine session if it is felt the videoconferencing connections are not adequate for the situation. In the event of technical difficulties that result in the telepsychiatry session being interrupted and not being able to be continued, alternatives to the telepsychiatry session will be made available to me, including finishing the session by telephone, rescheduling the telepsychiatry appointment or scheduling a face to face appointment at an alternate site as available. I also understand the likelihood of a video conference being intercepted by an outsider is similar to the potential interception of a phone call.
5. I understand the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records. I understand that my healthcare information may be shared with other individuals within HM for scheduling and billing purposes.
6. When I am receiving services via telepsychiatry. I will be notified of the location of the psychiatrist at the secondary site. I will also be informed if there are any other staff who are in the room other than the psychiatrist at the secondary site. I understand staff other than my psychiatrist may be present during the consultation in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand I will be informed of their presence in the consultation and thus will have the right to request the following: (1)that I omit specific details of my psychiatric history/clinical record that are personally sensitive to me; (2)ask non-medical personnel to leave the telemedicine examination room; and/or(3)terminate the consultation at any time.
7. I have read this document and I hereby consent to participate in receiving behavioral health services via telepsychiatry under the terms described above. I understand this document will become a part of my clinical records.

Client Signature_____Date: _____

Witness Signature and Title:_____Date:_____

The above release is given on behalf of _____because the recipient is a minor or has been determined to be incompetent to give medical consent.

_____ _____

Parent/Legal Guardian/Govt. Agency/Authorized by Court Date