PATHWAY
PSYCHIATRY & COUNSELING CENTER

TELEPSYCHIATRY CONSENT FORM

Telepsychiatry provides psychiatric services using interactive video conferencing tools, similar to Skype (but more secure and HIPAA compliant), in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care 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. Alternatives 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 the software being used (VSee) 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 VSee at https://vsee.com/hipaa
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. Gardner 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 Texas also apply to telepsychiatry.

Your Responsibilities:

1. I will not record any telepsychiatry sessions without the prior written consent of Dr. Gardner and I understand that Dr. Gardner will not record telepsychiatry sessions without my consent;
2. I will inform Dr. Gardner if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Gardner will inform me if any other person can hear or see any part of the session before the session begins. This is so that your privacy can be protected.
3. I understand that I MUST be a resident of Texas to be eligible for telepsychiatry services from Dr. Gardner.

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

_____

Printed Name

_____ _____

Signature Date

PATHWAY
PSYCHIATRY & COUNSELING CENTER

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:
1-800-201-9353
For more information please visit our website at www.tmb.state.tx.us