White Marsh Psychiatric Associates, LLC
5024 Campbell Blvd, Suite H
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Addendum to Policy, Procedures, and Consents: Informed Consent for Telehealth Services

I understand that this informed consent for telehealth service is in addition to the general "Policy, Procedures, and Consents." In order to utilize telehealth services with providers at White Marsh Psychiatric Associates, LLC (WMPA) I must first be seen for evaluation face to face with my provider. Following that initial session my provider and I will determine if telehealth services are appropriate.

Definition of Telehealth
Telehealth involves the use of electronic communication to allow your provider at WMPA to conduct your appointment using interactive audio and video communications.
Telehealth includes the practice of psychiatry and psychological health care delivery, diagnosis, consultation, treatment, referral, education, and includes the transmission of potentially sensitive medical and clinical data.

I understand that I have the following rights with respect to telehealth services:

1. The laws that protect confidentiality of my personal information also apply to telehealth. As such I understand that the information disclosed by me during the course of my telehealth session is generally confidential. However, there are exceptions to that confidentiality including, but not limited to, reporting child abuse and/or neglect of a child under the age of 18, abuse of vulnerable adults, suicidal intent and plan, expressed threats directed at a specified victim, and where I make mental/emotional state a concern in legal issues.
2. I understand that I have the right to withdraw my consent to telehealth at any time. My withdraw of consent for telehealth will not impact my right to future care or treatment in other modalities of services (ie face to face)
3. I understand that telehealth has specific risks and consequences, including, but not limited to, information being disrupted/distorted by technical failures, information being interrupted by unauthorized persons, and the possibility that unauthorized individuals may gain access to my protected health information. WMPA takes all steps necessary to maintain the security of telehealth communication in accordance with applicable standards set forth by licensing bodies and government agencies.
4. I agree to provide an emergency contact and I am aware that my provider may discuss a safety plan specific to my telehealth treatment. Furthermore, I attest to knowing where the closest emergency room is to my specific location.
5. I understand that if my provider deems that telehealth is not the appropriate modality for my treatment, I will be able to see my provider for face to face sessions or I will be referred to another provider for treatment through other modalities. Furthermore, if I am currently seeing a provider for face to face services, my provider may also offer telehealth services and I am able to schedule sessions in either modality at my provider's discretion.
6. I will ensure that I have adequate technological skills to participate in the session. I assume responsibility for establishing a confidential environment and will not hold provider liable should confidentiality be breached due to my negligence. I can be assured that my provider will maintain a safe and secure confidential environment.

7. I understand that I may expect to notice improvements based on the access to my provider that telehealth services offer; however, no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals within WMPA for the purposes of scheduling and billing.
9. I understand that WMPA will make all efforts to submit your claim for telehealth services to your insurance carrier. WMPA cannot guarantee telehealth insurance benefits and I will need to be in contact with my insurance carrier to determine if telehealth services are covered. I assume the ultimate responsibility for my bill. I understand that co-pays, deductibles, and self-payment may apply, and I will be billed for applicable amounts.
10. I understand that if I am a minor, I will need permission from a parent or legal guardian to participate in telehealth sessions.
11. I understand that I may need to receive an email and/or text from my provider with access information to the telehealth session. I will respect the email and/or phone number of provider and will not utilize email and/or text for any other purpose other than to access my telehealth session. I authorize WMPA to contact me through text at _____(carrier:_____) or through email at _____ for the purpose of sending a link for my telehealth session.

Patient Consent to the use of Telehealth Services

I have read and understand the information provided above regarding delivery of services through telehealth. I was given an opportunity to ask any questions related to this document with my provider and my questions were answered to my satisfaction.

I have read this document carefully and understand the specific risks, benefits, and expectations related to the use of telehealth. I hereby give my informed consent to participate in the use of telehealth services for the treatment of myself or minor child.

By my signature below, I hereby state that I have read, understood, and agree to this informed consent.

_____

Patient Name Printed

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Emergency Contact/Relationship Phone #