Telehealth Consent Form

I hereby consent to engage in Telehealth with Orange Psychiatric Medical Group, Inc.

I understand that Telehealth is a mode of delivering health care services, including medication management and psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self management of a patient's mental health care.

By signing this form, I understand and agree to the following:

I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form also apply to my Telehealth services.

1. I hereby consent to engage in Telehealth with Orange Psychiatric Medical Group, Inc
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD), that my medication management/psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electrical storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD) may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD) is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person medication management/therapy. I understand that if my therapist believes I would be better served by in-person medication management/therapy, my Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD) will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other providers who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I agree to have my insurance plan billed for Telehealth (unless I am paying out of pocket) and that I will pay the portion that is my responsibility as a co-payment. If I am paying out of pocket, I will pay the out of pocket costs.
10. I understand that my Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD) will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my Psychiatrist, Nurse Practitioner, Therapist (LMFT, LCSW, PhD, PsyD) may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

    I have read and understand the information provided above and understand that I have the right to have all of my questions regarding this information answered to my satisfaction.

_____ _____

Patient (parent) Signature Date

_____ _____

Patient Name (Please Print) Date of Birth of Patient