RIDDLE PSYCHIATRY
484-444-2151

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TELEHEALTH INFORMED CONSENT

Telehealth is a healthcare provided by any means other than face-to-face visits. In telehealth services, medical and mental health information is used for diagnosis, consultations, treatment, therapy, follow up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, Videoconferencing, transmission of still images, email, patient poralts and remote patient monitoring are all considered telehealth services.

1. Understand that telehealth involves communication of my medical and mental health information in an electronic or technology assisted format.
2. I understand that I may opt out of telehealth visits at any time. This will not change my ability to receive future care at Riddle Psychiatry, but may affect my ability to see my current provider.
3. I understand that telehealth billing information is collected in the same manner as regular office visits, and visit fees are the same for face-to face visits and telehealth visits at Riddle Psychiatry.

   I understand that if technology fails for videoconferencing session, the visit will be moved to a phone appointments, and there will be no change in visit fees.
4. It is my responsibility to verify if my insurance covers telehealth services before making an appointment. Understand that it will be my responsibility to pay for the session if my insurance does not cover said services.
5. I understand that all electronic medical communications carry some level of risk. While the likelihood of risk associated with the use of telehealth in a secure environment is reduced, the risk are nonetheless real and important to understand.
6. I agree that information exchanged during my telehealth visits will be maintained by doctors, nurse practitioners, therapist, administrators and other providers involved in my care.
7. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications with others. The healthcare provider is not responsible for breaches in confidentiality cause by an independence, third party or by me.
8. I agree that I have verified to my healthcare provider my identity and current location in the connection with telehealth services. I acknowledge that failure to comply with these procedures may result in the termination of my telehealth visit.
9. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a patient, I agree to accept the responsibility for following my healthcare provider's recommendations - including further diagnostic testing, such as lab testing or an in-office visit.
10. If during the course of treatment, a patient's provider deems that they do not have the skill-set or resources to safely provide care to a patient virtually or otherwise (for example, if a patient is assessed as being high risk for self harm or suicide) the provider will discuss this directly with the patient, provide resources on finding local mental health professionals.
11. If a patient is being seen for addiction, face-to-face appointments may be required and the patient may be required to have random drug screens performed within 72 hours of the provider's request, throughout care. The provider may require continued face-to-face appointments, for safety purposes, at their discretion.

I certify that I have read and understand this agreement and that all my questions have been answered to my satisfaction.

Patient Signature:_____ Date:_____

Prescriber Signature:_____ Date:_____