



RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services via interactive video conferencing tools, 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 I will download secured teleconferencing software, Spruce Health, to communicate with Dr. Mon
3. I have the right to withdraw my consent to the use of telepsychiatry during my care at any time.
4. I understand that Dr. Thetsu Mon has the right to withhold or withdraw consent for the use of telepsychiatry during 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. Mon and I understand that Dr. Mon will not record telepsychiatry sessions without my consent.
2. I will inform Dr. Mon if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Mon will inform me if any other person can hear or see any part of the session before the session begins.
3. I understand that I **MUST** be a resident of Texas to be eligible for telepsychiatry services from Dr. Mon.
4. I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to Dr. Mon's satisfaction before the evaluation.



RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

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

Patient's name (Print): _____

Patient's name (Signature): _____

Date: _____