Milwaukee Psychiatrists & Psychologists Chartered

Marie Ferber, MD * Eric Kanter, MD * Tracey Latza, PsyD * Margaret Regner, PhD * Gary Schnell, MD
Marina Tierney, PsyD * David Wandschneider, PhD * John Wean, MD * Randall Zblewski, MD

12760 W North Ave, Bldg A., Brookfield, WI 53005-4628 * Office: (262) 439-5500 * FAX: (866)439-5221
www.milwaukeepsychiatric.com

I, _____ [name of patient] hereby consent to engaging in telemedicine at Milwaukee Psychiatrists & Psychologists Chartered as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data and psychoeducation using interactive audio, video or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Wisconsin. Telemedicine has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telemedicine may be experienced somewhat differently than face-to-face treatment sessions.

Video/Audio Recording: As a general practice, Milwaukee Psychiatrists & Psychologists Chartered DOES NOT record telemedicine sessions without prior permission.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. I agree to have my credit/debit card information on file with MPPC. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, MPPC will cancel my appointments and I will be charged in accordance with the cancellation policy.

Client using insurance: I am responsible for contacting my insurance company, if applicable, to determine coverage and what out-of-pocket costs will be.

Self-Pay clients: I am aware that the fees associated with telemedicine appointments are the same as if I were present in the office for a face-to-face visit.

Scheduling: I understand that scheduling is conducted through MPPC and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency services or crisis services.

Client's Right, Risks and Responsibilities:
I understand that I have the following right with respect to telemedicine:

1. I, the client, have the right to withhold or withdraw consent at any time.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment at MPPC.
3. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my doctor, that the transmission of my medical information could be intercepted, disrupted or distorted by technical failures. In addition, I

understand that the telemedicine-based services and care may not be as complete as face-to-face services.

4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telemedicine. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telemedicine sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telemedicine session. It is the responsibility of the provider to do the same on their end.
5. I understand that telemedicine does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

I have read and understand the information provided above. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____

Client Signature Date

_____ _____

Client Guardian's Signature Date

_____ _____

Provider Name & Signature Date

Please return to:
Email: info@milwaukeepsychiatric.com
U.S. Postal Address: 12760 W North Ave, Brookfield, WI 53005