**CONSENT TO PARTICIPATE IN A TELEMEDICINE VIRTUAL VISIT AND HIPAA AUTHORIZATION**

**OVERVIEW**: To better meet the needs of our patients, New Journey Psychiatry offers mental healthcare services through telemedicine virtual visits (also referred to as “telemedicine” or “telehealth”).

1. **BENEFITS OF USING THE SERVICE**
	1. It offers more ways to connect with provider since these visits do not need to be in person.
	2. It allows me to get timely and convenient medical advice from my provider.

1. **POTENTIAL RISKS OF USING THE SERVICE**

As with any medical intervention, there are potential risks that come with virtual visits. These risks may include, but are not limited to:

1. **Technical issues**: A poor Internet connection may reduce my provider’s ability to do a proper exam, and may affect the assessment or diagnosis of my condition and treatment. Delays in evaluation, consultation or treatment may also occur due to problems with technology.
2. **Limited access to patient information**: I will not receive a complete physical examination during a virtual visit. Moreover, my provider’s assessment will be based, in part, on the information or images that I give to him or her. Incomplete information may result in reducing my provider’s ability to make an accurate diagnosis. An in-person visit may be needed.
3. **Information security**: New Journey Psychiatry uses end-to-end encryption to keep my data safe, but I must do my part, including logging in from a secure Wi-Fi network and having my visit in a private location. The security of my information is not guaranteed.

1. **ALTERNATIVES TO USING THE SERVICE**

I may choose to have in-person visits with my provider instead of using this technology.

1. **PRIVACY AND SECURITY**The telemedicine virtual visit service follows patient privacy and confidentiality laws about protected health information (PHI) as outlined by the Health Insurance Portability and Accountability Act (HIPAA). These laws require my provider to get my authorization before sharing information that can identify my child to a third party for purposes other than treatment, payment or health care operations.
	1. I understand that use of this service requires the electronic exchange of my medical information from one place to another. I understand that I will use this service to send my health information and talk with my provider.
	2. I understand that securely sending my information cannot be guaranteed. I understand that electronic exchanges may have errors, delays, disruptions or distortions. I understand that New Journey Psychiatryhas taken steps to help keep this from happening. I also understand that New Journey Psychiatrywill protect the security of the information and keep it confidential in accordance with law.
	3. Although unlikely, I am aware of the potential risk for PHI to be re-disclosed by the recipient, and no longer protected by the Privacy Rule under HIPAA.
	4. I understand the purpose of the virtual visit is for medical use only. Providers do not consent for myself, my child or any individuals participating in the visit to capture, save, store or share any audio or video recordings of any portion of the virtual visit.
	5. I understand that a limited visual physical examination will take place during the telemedicine virtual visit and that I have the right to ask my child’s health care provider to stop the virtual visit at any time.
	6. I understand that some parts of the exam involving physical tests may need a referral to other healthcare providers near me.
	7. I understand that my child’s health care provider may bill for professional services and for any additional fees related to the telemedicine virtual visit services described above.
	8. I understand that even if my child has a telemedicine virtual visit, my child may still need an in-person visit to my child’s health care provider or referral to a clinic or specialist for further in-person evaluation and treatment.
	9. I understand that my choice to not participate in the telemedicine virtual visit will not interfere with any current or future care that I receive and there will be no penalty or loss of benefits.
	10. I understand that I may revoke this Authorization in writing; however, information during my visit that has already been transmitted prior to my decision to withdraw may not be able to be deleted and/or removed.
	11. I understand that I may take back my consent to participate in a telemedicine virtual visit at any time by telling my health care provider verbally or in writing. As long as this consent is in effect, my health care provider may provide health care services to me through a telemedicine virtual visit without me signing another consent form.

**PATIENT REPRESENTATIVE/PATIENT SIGNATURE**

I agree to participate in a Telemedicine Virtual Visit with New Journey Psychiatryand authorize my provider to use virtual visit services for direct consultation via 2-way, live video communication technology to assist in making decisions about my child’s care. I have read this document carefully and understand the benefits and risks of telemedicine virtual visits. All of my questions have been answered. This Authorization does not have an expiration date.