



Initials _____

psychiatrie.me

CONSENT FOR OUTPATIENT TELEPSYCHIATRY SERVICES

1. CONSENT TO TREAT

I, _____, voluntarily consent that I am presenting myself for outpatient psychiatric evaluation and/or treatment of a psychiatric disorder and that I wish to participate in such evaluation and treatment by a duly licensed physician from *psychiatrie.me PLLC*. I hereby consent to and authorize *psychiatrie.me*, and its physicians, to perform psychiatric evaluations, diagnostic assessments, clinical and laboratory testing, therapeutic interventions, and treatments that in their judgment may promote my mental health.

I understand that I have the right to refuse any suggested examinations, tests, or treatments. I understand that the evaluation and/or treatment will be provided by a duly licensed and board-certified psychiatrist within the scopes outlined by the Maine Board of Licensure in Medicine, Massachusetts Board of Registration in Medicine, New Hampshire Board of Medicine, Vermont Board of Medical Practice, the National Board of Physicians and Surgeons, and the American Board of Psychiatry and Neurology. I understand that I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a request to *psychiatrie.me*.

2. DESCRIPTION, PURPOSE, AND BENEFITS

This outpatient psychiatric treatment is indicated for evaluation and/or treatment of a psychiatric disorder. I understand that the outpatient treatment proposed by the physician responsible for this care may consist of psychotherapy and/or psychotropic medication supervision. I further understand that the anticipated benefit of this treatment is to stabilize and/or improve my mental health.

I have been informed that videoconferencing equipment will be used to provide a physician encounter via real-time interactive services. I also have been informed that the encounter will be somewhat different from an in-person patient encounter due to the fact that I will not be in the same room as my psychiatrist. Telepsychiatry allows for more convenient and accessible psychiatric services and *psychiatrie.me PLLC* utilizes a HIPAA-compliant telepsychiatry platform (Zoom) to deliver those services.

3. LIMITATIONS AND RISKS ASSOCIATED WITH OUTPATIENT PSYCHIATRIC TREATMENT AND TELEPSYCHIATRY

I understand that there are risks associated with psychiatric treatment generally, and that there are particular limitations associated with telepsychiatry. I understand that the usual and most frequent risks involved in psychiatric treatment include:

- stimulation of unexpected and unpleasant memories of past experiences;
- experience of intense or uncomfortable feelings or impulses that seem difficult to control;
- examining, being challenged, or being confronted on a particular issue;
- unanticipated changes in my interpersonal relationships and how I feel about them; and
- lack of improvement in my condition.



psychiatrie.me

CONSENT FOR OUTPATIENT TELEPSYCHIATRY SERVICES

It has been explained to me that there are some limitations and risks inherent in telepsychiatry, as compared to in-person treatment, and that these include:

- a psychiatrist's inability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio;
- interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or result in a premature end to the encounter;
- unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information;
- patient utilization of a third-party connection to participate in the telepsychiatry encounter at home, which may become insecure, resulting in a breach of my protected health information;
- the presence of third parties in my home who may overhear the telepsychiatry encounter, which may result in a breach of my protected health information; and
- the inadvertent transmission of images of third parties present in my home or of furnishings and personal possessions.

I further understand that telepsychiatry is not suitable to provide a diagnosis and treatment plan for every psychiatric disorder. Additionally, the treatment of certain disorders may require the use of equipment not available in a telepsychiatry encounter. The physician performing the telepsychiatry encounter will inform me whether outpatient treatment delivered by telehealth platform is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality. If after a psychiatric evaluation or during the course of treatment, it is determined by my physician that my particular medical needs require in-person treatment, *psychiatrie.me* or its physicians will assist in referring me to another practice.

If medication is prescribed to me, I understand that the risks, benefits, alternatives, and side effects of such medication will be reviewed. I understand that psychiatric treatment remains an inexact science and no guarantees can be made regarding outcomes.

I understand that the Ryan Haight Act of 2008, which was created to regulate online prescriptions, and which is enforced by the Drug Enforcement Agency, imposes rules around the prescription of scheduled or controlled medications. I have been informed that scheduled or controlled medications, such as opioids, stimulants, sedative hypnotics, and anxiolytics cannot be prescribed during a telepsychiatry encounter and I understand that these medications will not be prescribed by *psychiatrie.me* or its physicians.

4. DURATION OF TREATMENT

The length of treatment for psychiatric disorders varies widely among individuals. The psychiatrist involved in this care shall periodically review treatment progress and the anticipated duration of treatment.

5. ALTERNATIVE COURSES OF TREATMENT

The psychiatrist responsible for this care has explained to me that outpatient treatment is the only recommended form of treatment at this time and that higher levels of care such as partial hospitalization, inpatient hospitalization, and residential treatment may be recommended if my condition does not improve.



psychiatrie.me

CONSENT FOR OUTPATIENT TELEPSYCHIATRY SERVICES

I understand that the alternative to outpatient telepsychiatry treatment is to visit another psychiatry practice for an in-person psychiatric evaluation, diagnostic assessment, and treatment which may not occur as quickly as a telepsychiatry encounter can be performed. I have been informed that I may seek other forms of treatment at any time, if I so choose.

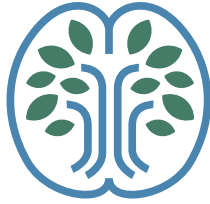
7. DISCLOSURE OF SUBSTANCE USE DISORDER TREATMENT RECORDS

If I receive treatment by a federally-assisted alcohol or substance use disorder diagnosis or treatment program, then I understand that the program, clinic, or practice will, when necessary, obtain my specific consent on a separate authorization form to disclose related information to *psychiatrie.me PLLC*. I understand that *psychiatrie.me PLLC* will not re-disclose records received from a federally-assisted alcohol or substance use disorder diagnosis or treatment program, without my separate written consent.

I understand that other information relating to the diagnosis and treatment of an alcohol or substance use disorder or substance misuse (that is, information other than the records of federally-assisted alcohol or substance use disorder treatment programs) will be available within the *psychiatrie.me PLLC* medical record, including the problem list, medication list, diagnosis and allergy fields; to complete the responsibilities of the physician involved in my diagnosis and treatment; and included in documents shared with other practices for purposes related to transitions of care.

8. MY RIGHTS AND RESPONSIBILITIES

- I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that all the Maine, New Hampshire, Vermont, Massachusetts state rules and regulations which apply to psychiatry also apply to telepsychiatry.
- I understand that I must be physically located within Maine, Massachusetts, New Hampshire, or Vermont in order to be eligible for telepsychiatry services. I will inform my psychiatrist as soon as my session begins of my physical location.
- I will ensure that the proper configuration and functioning of all my electronic equipment prior to my session. I understand the computer, tablet, or mobile device I use must have a working camera and audio input so that my psychiatrist can see and hear me in real time.
- I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session.
- I will not record any telepsychiatry sessions and I understand that my psychiatrist will not record any of our telepsychiatry sessions.
- If I lose connection during a session, I will immediately attempt to log back into the telepsychiatry appointment or contact my psychiatrist via phone, text, or email.
- If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or if disconnected, will call to schedule a new appointment.
- I understand that if I am billing my insurance company for telepsychiatry services, it is my responsibility to understand the specifics of how my insurance covers the services provided by *psychiatrie.me PLLC* and its physicians.



psychiatrie.me

CONSENT FOR OUTPATIENT TELEPSYCHIATRY SERVICES

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to outpatient telepsychiatry services, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in outpatient telepsychiatry services as described here and for purposes of encounter, examination, evaluation, assessment, diagnosis, and treatment.

Signature of Patient

Date

Printed Name of Patient

