THE FORT CHRISTIAN PSYCHIATRIC CENTER
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PATIENT INFORMATION AND INFORMED CONSENT FOR TELE-PSYCHIATRIC SERVICES

Please read the following information very closely and in its entirety. Initial each section where indicated.

Telepsychiatry, a form of telemedicine, is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged. X_____

REQUIREMENTS

• A computer with a webcam and microphone (and/or a smart phone) to allow video conferencing using Doxy.me (www.doxy.me), a telemedicine software available to all computer users. X_____

POTENTIAL BENEFITS

• Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office, living quite a distance away from our physical office location, or during a national and/or global crisis like the COVID-19 pandemic. X_____

POTENTIAL RISKS

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist. X_____
- The provider may not be able to provide medical treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure. X_____
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment. X_____
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information. X_____
- A lack of access to all the information that might be available in a face-to-face visit but not in a telepsychiatry session may result in errors in medical judgment. X_____

My Rights

- I understand that the laws (HIPAA) that protect the privacy and confidentiality of medical information will also apply to telepsychiatry. X_____
- I understand that the Doxy.me technology used by the provider is encrypted to prevent unauthorized access to my private medical information. X_____
- I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. X_____
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during the course of my care at any time. X_____
- I understand that all rules and regulations, which apply to the practice of medicine in the state of Georgia, also apply to telepsychiatry. X_____
- I understand that the provider will not record any of our telepsychiatry sessions without my written consent. X_____
- I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my expressed written permission. X_____

My Responsibilities

- I will not record any telepsychiatry sessions without written consent from the provider. I will inform the provider if others can hear or see any part of our session before the session begins. X_____
- I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and agree to revert to a telephone session utilizing the indicated backup telephone number provided below should a video connection not function properly. I understand any time lost as a result of computer malfunction is my responsibility, and the session will not be extended. X_____
- I have read and understand that all practice policies of The Fort Christian Psychiatric Center (TFCPC) apply to all telemedicine as well as all in-person visits. X_____
- I understand that I agree to be seen face-to-face at least once a year to maintain therapeutic services and a provider-patient relationship. X_____
- I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in The Fort Christian Psychiatric Center's office face to face prior to commencing telepsychiatry treatment. X_____
- I understand that my credit card on file will be charged the cost for the session, including a $10 fee/session, prior to the start of the session. I understand that the length and format of the telemedicine session will be the same as that of an in-office session at TFCPC. X_____
- I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be scheduled, and if I am not able to be present for the appointment or if I don't cancel it by the designated deadline (48-business-hours prior to the date and time of my appointment or 1 week prior), it will be charged as a missed appointment for the time my practitioner has reserved for the scheduled appointment. X_____

Data and Signature Page

Patient's Consent to the Use of Telepsychiatry

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider, Dr. Fortuchang, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Dr. Fortuchang to use telemedicine in the course of my diagnosis and treatment. X_____

First Name: _____ **MI:** _____ **Last Name:** _____

DOB: _____/_____/_____ **Gender:** □M □F **Email:** _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Home Phone:** _____ **Cell Phone:** _____

Place of Employment: _____ **Work Phone:** _____

I am: ___Married ___Single ___Other ___Employed ___Full-time Student ___Part-time Student

***The following back-up telephone numbers will be called in order to continue an interrupted video session:**

Patient's back-up telephone number (if different from above): (_____) _____-_____

Alternate back-up telephone number (if different from above): (_____) _____-_____

Emergency Contact: _____ _____
First Name Last Name

_____ _____
Best Phone Number Relationship to Patient

Indicated below is the telemedicine provider you will be seeing under this agreement/consent:
(X) Shaw Wendi Fortuchang, M.D., FAPA

Your Signature: _____
Patient ( )
Guardian if patient is under 18 years of age ( )
Relationship of guardian to patient: _____

Printed Name of Patient or Guardian: _____

Date: _____/_____/_____

Tele-Mental Health Providers and Local Resources:

Primary Care Physician: _____

Name of practice: _____

Address: _____ Phone # _____

Therapist/Counselor: _____

Name of practice: _____

Address: _____ Phone #: _____

Email: _____ Comments: _____

Primary Contact Person: _____

Address: _____ Phone #: _____

Email: _____ Relationship to Patient: _____

Comments: _____

Back-Up Contact Person: _____

Address: _____ Phone #: _____

Email: _____ Relationship to Patient: _____

Comments: _____

Pastor / Spiritual Leader: _____

Address: _____ Phone #: _____

Email: _____ Comments: _____

Nearest Hospital Emergency Room: _____

Address: _____ Phone #: _____

Nearest Psychiatric Hospital: _____

Address: _____ Phone #: _____

Local Police Department: _____

Phone #: _____