Angel Oak Counseling

Patient Information and Consent Form for Telepsychiatry

Patient Name: _____ Date of Birth _____

Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location.

The interactive electronic systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

My Rights

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

I understand that the telepsychiatry platform used by Angel Oak Counseling is encrypted to prevent the unauthorized access to my private medical information.

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.

I understand that the Angel Oak Counseling provider has the right to withhold or withdraw his consent for the use of telepsychiatry during the course of my care at any time.

I understand that the all rules and regulations which apply to the practice of medicine in the state of South Carolina also apply to telepsychiatry.

My Responsibilities

I will not record any telepsychiatry sessions without written consent from the Angel Oak Counseling provider. I understand that all Angel Oak Counseling providers will not record any of our telepsychiatry sessions without my written consent.

I will inform the Angel Oak Counseling provider if any other person can hear or see any part of our session before the session begins.

Any Angel Oak Counseling provider will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not the Angel Oak Counseling provider, am responsible for the configuration of 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.

I understand that I must be a resident of the state of South Carolina to be eligible for telepsychiatry services from Angel Oak Counseling.

I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will required to verify my identity to his satisfaction before the evaluation.

I understant that medication evaluation and management will require in office visits and will not be provided via telepsychiatry.

I accept financial responsibility for my appointments should my insurance provider not cover medical expenses related to telepsychiatry services.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with a Angel Oak Counseling provider and all of 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 Angel Oak Counseling to use telemedicine in the course of my diagnosis and treatment.

Credit Card Authorization

I consent to Angel Oak Counseling having my credit card on file and understand that I will be billed for the balance of my session on the day of my appointment.

Credit Card Number: _____ **Billing ZIP Code**: _____

Credit Card Exp:_____ **CVV Code: _____**

Preferred Email For Telemedicine Link: _____

Signature of Patient (or person authorized to sign for Patient):_____

If authorized signer, relationship to Patient:_____ **Date:** _____