HUMAN DYNAMICS & DIAGNOSTICS

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Patient Information and Consent Form for Telepsychiatry Introduction

Client Name: ________________________________

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 the patient's information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Medical Provider is defined as a Doctor of Medicine duly licensed and employed by or contracted with Human Dynamics and Diagnostics LLC.

Potential Benefits:
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 Medical Provider.
- Medical Provider may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- 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.
- Traditional face to face sessions in Medical Provider's office.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the technology used by Medical Provider 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 may affect

future access to care or treatment due to rural nature of Idaho and scarcity of Psychiatry Medicine service providers.
- I understand that Medical Provider has the right to withhold or withdraw his/her consent for the use of telepsychaitry during the course of my care at any time.
- I understand that all rules and regulations which apply to the practice of medicine in the state of Idaho also apply to telepsychiatry.

My Responsibilities

- I will not record any telepsychiatry sessions without written consent from Medical Provider. I understand that Medical Provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform Medical Provider if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Medical Provider, am responsible for the configuration of any electronic equipment used on my personal computer which is used for telepsychiatry. I understand that I must be eligible for telepsychiatry services from Medical Provider and be eligible for the service under any third party payer such as Idaho Medicaid or any other insurance company.
- I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will require to verify my identity to his satisfaction before the evaluation.

Patient Consent to the use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Medical 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 authorized Medical Provder, to use telemedicine in the course of my diagnosis and treatment.

______________________________ ____________________

Patient Signature Date

______________________________ ____________________

Guardian/Parent if applicable Date