Four Winds SARATOGA a psychiatric health system **TELEMEDICINE APPOINTMENT INFORMED CONSENT FORM**	Patient Name DOB MRN

Four Winds Psychiatric Services, P.C. Telepsychiatry uses two-way communication through audio and video equipment to provide mental health services to you at a distance. Telepsychiatry allows you and staff at different locations to interact and provide care without the need to travel long distance.

Expected Benefits

Telepsychiatry can be a benefit to you, when on-site services are not available because of the distance, location, time of day, or availability of resources. Some benefits to Telepsychiatry are:

- Improved access to care
- Timely services
- Improved coordination of care
- Improved treatment of care

Potential Risks

There are possible risks with the use of telepsychiatry. These risks could include:

- Delays in treatment due to equipment failure
- Poor picture and delays in the video
- Potential data transmission problems that happen in very rare instances, but could lead to a breach of your information
- A lack of information that might be available in a face to face visit but not in a Telepsychiatry session may result in errors in medical judgment

You have the right to:

If you choose to participate in Telepsychiatry services, you are given additional Client Rights including being informed of:

- What trained staff will be available to you and providing you services at the distant site and who can help in an emergency.
- How the Telepsychiatry equipment works and the purpose of videoconferencing technology.
- Who is in the room at each location during the Telepsychiatry session
- Your opportunity to decide about who will be in the room with you during telepsychiatry sessions, as well as the right to ask non-medical personnel to leave the room at any time if not needed for safety concerns.

Failure of Transmission

In the event your session is dropped as a result of transmission or equipment failure someone from the office will contact you. We would need to be sure that any alternative contact methods are encrypted and secure. This may mean a follow up in-person appointment or an additional telepsychiatry session to complete the appointment.

I understand this service is not the same as a direct provider visit, because I will not be in the same room as the provider performing the service. Parts of my treatment which involve physical tests/examinations such as taking my vital signs and blood pressure will not be completed. I understand that my telepsychiatry provider will be my local provider I would normally see in the office setting. Also,

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- I have the right to refuse or withdraw my consent to telepsychiatry sessions at any time, without affecting my right to future care or treatment.
- I understand this is temporary due to the recent COVID19 state and federal restrictions put in place.
- If my provider decides my health care can no longer be managed through telepsychiatry, services may be discontinued. Other options for my care will be discussed with me.
- Telepsychiatry sessions shall not be recorded without my consent.
- Written medical information and telepsychiatry sessions are kept confidential the same as in-person medical records.
- I agree to allow individuals other than my provider and remote provider to be present during my telepsychiatry service to operate the video equipment, if necessary. Also, if additional persons are needed for safety concerns, then my permission may not be needed.

☐ We have read the Telepsychiatry consent form to the patient/legal guardian and we witnessed the consent of telepsychiatry through the Four Winds PC program. The patient/family has had an opportunity to ask questions which I've answered to the best of my knowledge.

Staff1: _____ Date/Time _____

Staff2: _____ Date/Time _____

Dear Patient/Family,
Upon receipt of this form, please read through the consent above and the statement below. Sign and return to the office at your earliest convenience. Please know you have given verbal consent for your first session. After reading this form, should you change your mind please notify the staff immediately.

Four Winds Saratoga
Outpatient Program
30 Crescent Ave Saratoga Springs NY 12866

I have read and understand the information provided above regarding telepsychiatry. I have discussed the expected benefits, potential risks, as well as possible alternatives to telepsychiatry with my provider. All of my questions have been answered to my satisfaction. I hereby authorize Four Winds Psychiatric Service P.C to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient/Legal Guardian: _____Date:_____

Print Name of Patient/Legal Guardian: _____