SUMMIT MEDICAL GROUP

SummitMedicalGroup.com

INFORMED CONSENT for PARTICIPATION IN TELE-PSYCHOTHERAPY AND TELE-PSYCHIATRY HEALTH SERVICES

Service	Tele - psychotherapy & psychiatry is the delivery of psychotherapeutic and/or psychiatric services using an interactive audio and visual (video) system. This interactive electronic system incorporates network and software security protocols to protect patient information and safeguard the data exchanged. Summit Medical Group ("SMG") will use videoconferencing software from a third-party vendor to deliver telepsychiatry services. The use of these services is at the discretion of the provider and may be withheld or withdrawn at any time. The provider may also determine whether there is a need for an in-person visit and therefore request a face to face session.
Specific Instructions	I understand that the provider will have access to relevant medical information including psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records. I am aware that I must conduct tele – psychotherapy and/or psychiatry sessions from a consistent location and provide the location details to my provider in the event he or she determines I need emergency resources (e.g., police, emergency room, crisis team). I understand that my provider may consider the use of a "Patient Support Person" (PSP). A PSP is a family member, friend, or community member I select who can be called upon for support in the case of an emergency. My provider may contact this person to request assistance in evaluating the nature of an emergency and/or initiating 9-1-1 from my location. I am aware that if I and/or my PSP do not cooperate in my own emergency management, my providers will work with local emergency personnel in the event I need emergency services and/or involuntary hospitalization. I will inform the provider if any other person can hear or see any part of our session before the session begins. I understand there may be times where additional persons are involved in a videoconference session, and that they will be identified prior to the session beginning. Additionally, I understand that my permission is not required for others to participate in these sessions if a safety concern mandates the presence of another individual or if I am being legally detained. I am aware that I will need to have access to a computer with a webcam/internet for each visit and that I will be given instructions on how to set up an account with the telehealth service selected. I understand that the third-party software incorporates network and security protocols to protect the confidentiality of patient information and that SMG does not control the effectiveness of these security measures. I understand sessions are not to be recorded without the consent of my provider. My participation in Tele - psychotherapy & psychiatry is voluntary and I may refuse to participate or decide to stop participating at any time.

SUMMIT MEDICAL GROUP

SummitMedicalGroup.com

Risks & Benefits	Risk(s): As with any medical treatment, there may be potential risks associated with the use of tele - psychotherapy & psychiatry. These risks include but may not be limited to: insufficient transmission of information due to connection failure, equipment failures or deficiencies, security breaches/failure to maintain confidentiality, delay in evaluation/treatment due to poor connections, inability to provide medical treatment or emergency care via electronic equipment. Benefit(s): Tele - psychotherapy & psychiatry benefits may include increased access and continuity of care. The opportunity to include family members in treatment, for example, it allows providers to connect with people who may live out of state and may otherwise not be able to attend sessions. Tele - psychotherapy & psychiatry provides more flexibility in scheduling and convenience in being able to connect from a space of my choosing.
Patient Responsibilities	I understand that because tele - psychotherapy & psychiatry health services take place in a professionally unsupervised settings it requires that I take a more active and cooperative role in the treatment process. I have read and signed the patient – therapist agreement and understand that it applies to all tele - psychotherapy & psychiatry as well as all in person visits.
Signature	I have read and understand the information provided above regarding tele - psychotherapy & psychiatry. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my consent for the use of tele - psychotherapy & psychiatry in my care and authorize the provider to use tele - psychotherapy & psychiatry during my diagnosis and treatment.

Patient (or person authorized to sign for Patient)	Date
Relationship to Patient if signing for Patient)	Date
Witness Signature (witness to patient signature only)	Date
Provider Signature	Date
Interpreter Signature (or ID# if using service), as applicable	Date