Pathways Counseling Center Inc.

Consent for services via telemedical equipment, telehealth or "Telepsychiatry"

Telepsychiatry/telehealth is the delivery of psychiatric and counseling services using interactive video conferencing that enables a psychiatrist or his/her associate at a distant location to provide treatment to the patient. This consultation will not be the same as direct patient/counseling/psychiatry visit. Telepsychiatry and/or telehealth will allow the patient to receive medical care through the use of audio and visual electronic equipment.

The interactive electronic systems used in the telepsychiatry and/or telehealth are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. We may use the landline telephone for audio if the need arises.

During the Telepsychiatry and /or Telehealth Consultation:

- Details of your medical history, current medications, and results of medical tests will be discussed.
- Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
- At times, support staff may be present during the session. You will be informed about who is present in the office.

Potential Benefits of Telepsychiatry and Telehealth:

- Increased accessibility to behavioral health care
- Patient convenience

Potential Risks of Telepsychiatry and/or Telehealth:

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

- Information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by the professional
- The professionals may not be able to provide medical treatment to me using interactive 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 failure 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/telehealth session may result in errors in medical judgement.

Alternatives to the Use of Telepsychiatry and/or Telehealth

- Traditional face-to-face sessions in our office.

My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry and telehealth.
- I understand that the technology used by Pathways Counseling Center, Inc. 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 to telepsychiatry or telehealth 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 professionals have the right to withhold or withdraw consent for the use of telepsychiatry/telehealth 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 Ohio also apply to telepsychiatry/telehealth.

My Responsibilities:

- I will not record any telepsychiatry/telehealth sessions completed at Pathways Counseling Center, Inc. or any other site. I understand that Pathways will not record any of our telepsychiatry and/or telehealth sessions.
- Pathways will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that Pathways is responsible for the configuration of any electronic equipment use in telepsychiatry and/or telehealth.
- I understand that I must be a resident of the state of Ohio to be eligible for telepsychiatry and telehealth services from Pathways Counseling Center, Inc.
- I understand that my initial evaluation will not be done by telepsychiatry/telehealth except in special circumstances under which I will be required to verify my identity to provider satisfaction before the evaluation.

______________________________ Print client name

______________ Date of Birth

______________________________ Signature ______ Date

Updated 01.05.2021

______________________________ Client's parent or guardian signature if minor ______ Date