GOODMAN PSYCHIATRIC GROUP, PLLC

INFORMED CONSENT FOR TELEPSYCHIATRY SERVICES

Introduction Telepsychiatry is the delivery of psychiatric services using interactive audio and video technology, where the patient and the provider are not in the same physical location.

Nature of Telepsychiatry Services I understand that I will be receiving health care services via interactive video conferencing technology. I understand that this service allows for diagnosis, consultation, treatment, and care management.

Potential Risks I understand that there are potential risks associated with the use of telepsychiatry, including but not limited to: * Technological failures (e.g., video connection drops, poor audio quality) that may interrupt the visit. * Security protocols could fail, causing a breach of privacy of personal medical information, although the platform used is HIPAA compliant. * In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Patient Rights * I have the right to withhold or withdraw consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment. * I have the right to inspect all medical information transmitted during a telepsychiatry consultation and may receive copies of this information for a reasonable fee. * I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

Patient Responsibilities * I agree to be located in a private, quiet, and secure area during my appointment to ensure confidentiality. * I will provide my current location at the start of each session in case of an emergency. * I will not record the session without the written consent of the provider.

Emergency Protocol I understand that telepsychiatry is not suitable for all crises. If I am experiencing a life-threatening emergency, I agree to call 911 or go to the nearest emergency room immediately.

Consent By signing below, I certify that I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____