

## TELEPSYCHIATRY INFORMED CONSENT

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Location of Patient during Telepsychiatry Session: \_\_\_\_\_

Email address: \_\_\_\_\_

### Introduction

This document is intended to show that, prior to receiving services via telepsychiatry, I have been informed as to what this form of psychiatric treatment involves, as well as the risks, benefits and alternatives to telepsychiatry, so that I can make an informed choice about receiving these services.

### What is Telepsychiatry?

Telepsychiatry is the form of psychiatric treatment performed through telemedicine, allowing patients to access psychiatric care using interactive audio-video communication by electronic means such as videoconferencing. Telepsychiatry is an alternative to direct, in person psychiatrist-patient encounters, allowing the patient to receive care without having to be physically present with the psychiatrist.

### Is Telepsychiatry Confidential?

Telepsychiatry is subject to the same confidentiality protections as other medical treatment information. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. However, as described below, no guarantee can be made that security protocols cannot be breached causing an unintended disclosure of access to my medical information.

### Expected Benefits of & Alternatives to Telepsychiatry

There are benefits associated with the use of telepsychiatry including the following:

- Improved convenience and access to psychiatric care by enabling a patient to remain in his/her home or office.
- More efficient psychiatric evaluation and management.
- Obtaining expertise of a distant specialist.

Although there are expected benefits from the use of telepsychiatry, no specific results or benefits can be guaranteed. The alternative to telepsychiatry is traditional face-to-face treatment with the patient and psychiatrist in the same location.

### **Possible Risks of Telepsychiatry**

As with any medical procedure, there are potential risks associated with the use of telepsychiatry.

These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical or psychiatric records may result in adverse drug interactions or allergic reactions or other medical judgmental errors.

### **Patient Rights and Responsibilities Regarding Telepsychiatry**

There are a number of rights and responsibilities for patients who agree to treatment by telepsychiatry including the following, which I understand and agree to:

- Videoconference technology used by the physician is encrypted to help prevent unauthorized access to my private medical information.
- Patients have the right to withhold or withdraw consent to the use of telepsychiatry during the course of their care; however, patients should, whenever possible, provide at least 30 days' notice before withdrawing consent for telepsychiatry so that the physician can help to facilitate a transition to a practice that conducts face-to-face treatment.
- All rules and regulations which apply to the practice of medicine in the District of Columbia and Virginia also apply to telepsychiatry.
- Patients may not record any telepsychiatry sessions without written consent from the physician. I understand that the physician will not record any telepsychiatry sessions without written patient consent.
- Patients must inform the physician if any other person can hear or see any part of a telepsychiatry session before the session begins. The physician will inform the patient if any other person can hear or see any part of the session before the session begins.
- Patients (and not the physician or staff) are responsible for the configuration of any electronic equipment used on their computers and smartphones which are used for telepsychiatry and patients are responsible for ensuring the proper functioning of all electronic equipment before each session begins.
- Patients must be physically present in the District of Columbia or Virginia state during appointments with the physician to be eligible for telepsychiatry services from the physician. At the start of each session the patient must tell the physician of his/her specific location to confirm presence in DC or Virginia, and in order to facilitate the provision of emergency services should the need arise.
- In the event of an equipment failure, part or all of the session may be conducted by telephone.
- As the videoconference appointment is initiated by the physician sending the patient an email invitation. Therefore, the patient must keep an email address on file, and by signing below, provide the physician or his staff permission to email the patient in the course of the professional relationship.
- I agree to indemnify and hold harmless Shlakman Psychiatric Services, LLC and

Samantha Shlakman, M.D., the provider, the provider's members, shareholders, directors, officers, employees, or agents (collectively the "Indemnified Parties") from and against any and all losses, claims, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses related to the defense of any claims (a "Loss"), which may be asserted against any of the Indemnified Parties in connection with this Agreement, from any Loss related to technical failures involved in the use of telemedicine.

**Patient Consent To The Use of Telepsychiatry**

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my physician or such staff as may be designated, 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. I hereby authorize my physician (Dr. Shlakman) to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

\_\_\_\_\_ Date: \_\_\_\_\_

If authorized signer, relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have been offered a copy of this consent form (patient's initials) \_\_\_\_\_