Empower Psychiatry & Sleep LLC.
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Telepsychiatry Consent

In order to receive telepsychiatry services from Empower Psychiatry & Sleep LLC, you must be a **Georgia State Resident**.

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:
Reduced wait time to receive psychiatric care.
Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:
-A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to- face service.
-There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision making capability of the provider.
-The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
-A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.
-Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
-Empower Psychiatry & Sleep LLC utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:
Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:
(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to- face services) I will be referred to such services. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist, my condition may not be improve, and in some cases may even get worse.
(4) I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Georgia Law.

Patient's Responsibilities
-I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
-I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
-I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
-I understand that I must be a resident of the State of Georgia to be eligible for telepsychiatry services from Empower Psychiatry & Sleep LLC.
-I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.
-I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to- face visit, or a second telepsychiatry visit.
-I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.

Patient Consent To The Use of Telepsychiatry:
I hereby consent to engaging in telepsychiatry with Empower Psychiatry & Sleep LLC as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Name of Patient:_____ Signature of Patient:_____

Date:_____