Maryland Centers for Psychiatry
Patient Consent to Participate in Telepsychiatry

Patient's Name: _____ DOB:_____

1. I understand that my mental health provider, Dr. _____, has recommended a TeleMental Health (TMH) appointment.

2. I understand that the TMH provider will use audio and video communications to interact with me/my child.

3. My mental health provider has explained to me how the video conferencing technology will be used during the consultation. I understand that this consultation will not be the same as a face-to-face mental health/healthcare visit due to the fact that I will not be in the same room as the mental health care provider I am seeing.

4. I understand that if my provider or I feel that I would be better served by another form of mental health services (i.e. face-to-face) I may elect to not participate in a TMH visit.

5. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the TMH session if it is felt that the videoconferencing connections are not adequate and may elect to use the telephone in order to continue the session.

6. The laws that protect the confidentiality of my medical information (HIPAA) also apply to TMH. I understand that my healthcare information may be shared with other individuals for scheduling and invoicing purposes. I have the right to terminate the session at any time.

7. I have had the alternatives to a TMH evaluation/follow-up explained to me.

8. In the event of an emergency, I understand that a crisis plan will be developed by my provider during the TMH session. My provider will assist to arrange transportation to the nearest emergency room if the crisis cannot be managed otherwise.

9. I agree to provide my TMH with my exact location at the time of the video teleconferencing call. I understand that my provider will need to document my location. I understand that I am only eligible for a TMH session if I am physically located in the state of Maryland during the time of the visit.

10. I understand that I will be billed the same amount for a TMH follow up appointment as an in-person appointment.

10. I have read this document carefully, and understand the risks and benefits of the teleconferencing follow-up. I have had my questions regarding the visit explained.

I hereby consent to participate in a TMH visit under the terms described herein.

_____ _____
Patient's/parent/guardian signature Date and Time

_____ _____
Witness signature Date and Time