Informed Consent for Treatment – Telemedicine

Connected Care Psychiatry PLLC

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The purpose of this form is to allow you to give informed consent for the use of video technology, referred to as telemedicine.

Please read the following informed consent and policies thoroughly for understanding and ensure all of your questions are answered before signing to give consent:

1. The purpose of our telemedicine is to diagnose and treat behavioral or mental health problems. Telemedicine can be useful to diagnose your problem, to recommend/provide therapy or therapeutic recommendations, to provide prescriptions or prescription refills, to schedule appointments, or to educate you. On the other hand, not every medical problem can be managed at a distance via telemedicine. Dr. Broszko will determine whether your condition is appropriate for diagnosis or treatment through a telemedicine encounter and, if so, what the proper way to manage it is. Depending on the nature of your problem, it may be necessary for you to follow-up with other providers. If so, Dr. Broszko will discuss this with you. Dr. Broszko will continue to re-evaluate periodically your appropriateness for telemedicine treatment. If at any point Dr. Broszko feels that you may not be appropriate for telemedicine treatment, he will proceed with alternate treatment recommendations.
2. The advantages of telemedicine include the ability to be treated from almost any location within North Carolina and at almost any time during our regular hours. Telemedicine may also enhance the continuity of your care and accessibility to care. Some patients may even be more comfortable interacting with a psychiatry provider through telemedicine than in-person.

3. Telemedicine relies on electronic communications and devices. These can fail at any time. Any technical failure or power outage could therefore delay or disrupt communication and hinder, delay, or erase our ability to assist you with telemedicine. Ordinarily, however, the technology works well. Barring technology failure, we do not anticipate having telemedicine sessions by phone. There may be times, however, when we need to contact you by phone. If you have a cell phone or other wireless or mobile phone, be advised that such phones are not absolutely secure and the privacy and security of information transmitted may be compromised. If you choose to contact us using a cell phone or other wireless or mobile phone, you agree to accept the risk to the privacy and confidentiality of your information that the use of such phones may pose.

4. I understand that I need to log into my visit early to assure the visit may proceed without any technical difficulties. Patients may be required to download a program named ZOOM to allow access to their devices audio and video and proceed with the visit.

5. Please be advised that no electronic communication is entirely safe from intruders. The risks of using telemedicine services include the potential for unauthorized disclosure of your confidential information when it is transmitted between you and us over the Internet. We take measures to protect your privacy, such as encrypting your data, employing password protected measures, and utilizing other reliable authentication techniques. These features reduce the risk of a data breach, but do not eliminate them. You can help reduce the risk further. You may be overheard by anyone near you if you are not in a private area during a telemedicine session. It is your responsibility to create an environment at your location for each telemedicine transmission that is private and protective of your personal information and communications with us. It is your responsibility to inform us if anyone else can see or hear any part of the session. At the start of each session, we will require you to identify anyone else who may be present in the room where you are or who may be able to overhear some or all of the conversation.* I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user

ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation and take full responsibility for the security/privacy of any communications or treatment on my own computer and in my own physical location.

6. As part of its commitment to privacy, Connected Care Psychiatry PLLC. does not record telemedicine sessions without the knowledge and consent of the patient. Connected Care Psychiatry PLLC also expects patients do NOT record or attempt to record any telemedicine encounters.
7. All existing confidentiality protections under federal and state law, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), apply to all telemedicine encounters.
8. You may request your protected health information by completing a release of information form. Once you obtain your records, it is your responsibility to maintain their confidentiality when in your custody and to arrange for their secure transmission to other providers as needed.
9. No patient-identifying information from a telemedicine consultation will be provided to researchers or other entities without the written consent of you or of your personal representative. No images or sound will be recorded in your telemedicine sessions without your knowledge and permission.*
10. The physical examination that Dr. Broszko can perform through telemedicine is limited. In particular, information that can be obtained only by physically touching the patient will not be available. Fortunately, physical examination in psychiatry may not impede any treatment, but to the extent that diagnosis depends on such physical exams, you may be referred to an alternate provider to manage your care.

11. You can withhold or withdraw consent to receive behavioral health services through telemedicine, or seek a second opinion, at any time. Doing so will not affect your right to receive future care or treatment. As such, if you choose to refuse telemedicine services, we would be happy to offer you a referral to another provider if required.

12. I understand that Dr. Broszko is licensed to practice Medicine in North Carolina and cannot provide care to any patient at Connected Care Psychiatry outside of the state of North Carolina. I understand that I must be physical present in the state of North Carolina during the time of my telemedicine appointment and that Dr. Broszko must confirm my identity with photo identification before initiating any telemedicine appointment. I must also provide a physical address/location before visit may proceed.

13. In some cases, applicable law may prevent us from providing the services you desire. Should that be the case, we will refer you to another provider.

14. Telemedicine is still a relatively new approach to care. It is possible that risks not yet identified or understood may energe as telemedicine is more widely used.

We Do NOT provide emergency care. If you think you are facing an emergency, or think that you might be facing an emergency such as Suicidal Thoughts, Please immediately call 911 or go to your nearest emergency room.

15.

PATIENT SIGNATURE,

Acknowledgement

I, (Type First and Last Name)*

am over eighteen (18) years of age and during the time of my telemedicine appointment, am physically present in the State of North Carolina.

I understand the information above and have had adequate time and opportunity to discuss it with Dr. Broszko. My questions have all been answered to my satisfaction in language I understand, I am not under the influence of alcohol or of any other drug that might make it harder to understand the information I have been given. I understand that this document when signed by me is legally binding and will become part of my patient medical record with Connected Care Psychiatry PLLC. At the time of my signature, all the blanks on this document have been filled in.

I hereby authorize Dr. Broszko and Connected Care Psychiatry to use telemedicine in the course of my diagnosis and treatment.

By typing your full name below, you agree to use the typed script as substitute for your handwritten signature. In doing so, you also confirm that you have read, understood and agree to all of the terms and conditions above.*

Name:

Date: