Holistic Child Psychiatry, LLC
Holistic Adult Psychiatry

Holistic Child Psychiatry, LLC
Phyllis J. Heffner, M.D.
10801 Hickory Ridge Rd.
Suite 215
Columbia, MD 21044
(410) 260-0344 - phone and fax

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

[NAME OF PATIENT] (hereinafter "**I**") seek the telemedicine consultation of [Holistic Child Psychiatry/Holistic Adult Psychiatry] ("**Practice**"). I am executing this Consent to Participate in Telemedicine Consultation ("**Telemedicine Consent**") to verify and confirm my discussion with [Phyllis Heffner, MD], a licensed [Psychiatrist and Functional Medicine Practitioner] (**"Provider"**) regarding the risks, benefits, and alternatives to the telehealth consultation services through Practice. I am seeking the telemedicine consultation services of Practice for my own purposes and not on behalf of any third party. I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time. I retain the option 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. I acknowledge that Provider may, in his or her sole discretion, determine whether the nature of my consultation is inappropriate for telemedicine, and may require me to come in for an in-person consultation. I agree to bring to the attention of Practice, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of Provider for further explanation until I have a full understanding before giving consent to any treatment or services.

1. **Purpose.** The purpose of this form is to obtain your consent for the use of telemedicine consultations with Provider. The purpose of the use of telemedicine consultations is to assist in the care and services provided by Practice and ultimately to assist in

2. **Nature of Telemedicine Consultation.** Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or educational purposes. During your telemedicine consultation, details of your medical history and personal history information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

3. **Risks, Benefits and Alternatives.** The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. Additional benefits are that patients may be diagnosed and treated earlier which can contribute to improved outcomes and less costly treatments. Potential risks of telemedicine include that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment.

Practice has taken the following steps to ensure the privacy of the telemedicine consultation:

- [We use only HIPAA compliant software through our Electronic Medical Record (EMR) software, teleconferencing software, and other electronic service providers;
- We have taken steps to encrypt data stored on local devices, if any;
- We use password protected screen savers and data files; and
- We use other reliable authentication techniques and safeguards, both electronically and physically, to reduce the likelihood of patient data or privacy breaches.]

In rare instances, technology failure may lead to the loss of information provided through telemedicine consultations. Additionally, in rare instances, security protocols could fail causing a breach of patient privacy. In rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reactions, or other judgment errors. You agree to hold Provider and Practice harmless from any such information loss, and any resulting judgments or decisions, due to technological failures outside of their agency or control. The quality of transmitted data may also affect the quality of the services provided via the telemedicine consultation. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. **Medical Information and Records.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation shall not occur without your consent.

5. **Confidentiality.** All existing confidentiality protections under federal and state law apply to information used or disclosed during your telemedicine consultation. However, there are both mandatory and permissive exceptions to confidentiality, which may allow or require disclosure of information used or disclosed during the telemedicine consultation. You will be informed of any parties who will be present from the Practice during your telehealth consultation, and will have the opportunity to exclude anyone from attending the consultation.

6. **Rights.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the right to be informed of and object to videotaping or other recording of the telehealth consultation.

By signing below, I acknowledge and certify that:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

- I have had opportunities to ask questions and have had them answered to my satisfaction.

- I have read and fully understand the foregoing Telemedicine Consent, and I have all of the knowledge I currently desire.

- I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

NOTE: Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing this form. Do not sign this form if you have taken medications which may impair your mental abilities or if you feel rushed or under pressure.

PATIENT

SIGNATURE: _____

PRINT NAME: _____

TITLE (if legal representative or guardian): _____

DATE: _____

I have explained this Informed Consent and answered all questions in layman's terms, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

PRACTICE

SIGNATURE: _____

PRINT NAME: __Phyllis J. Heffner, MD_____

DATE: _____