



VITAL PSYCHIATRY ASSOCIATES

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Patient Information and Consent Form for Telepsychiatry

INTRODUCTION

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location. The interactive electronic systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential benefits

- Increased accessibility to psychiatric care
- Patient convenience

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by Dr. Singh
- Dr. Singh may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.

- 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 medical judgment.

Alternatives to the use of telepsychiatry

- Traditional face to face sessions in Dr. Singh's office

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the Vsee technology used by Dr. Singh is HIPAA protected to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that Dr. Singh has the right to withhold or withdraw his consent for the use of telepsychiatry during the course of my care at any time.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Virginia, Washington D.C also apply to telepsychiatry.

My Responsibilities

- I will not record any telepsychiatry sessions without written consent from Dr. Singh. I understand that Dr. Singh will not record any of our telepsychiatry sessions without my written consent.
- I will inform Dr. Singh if any other person can hear or see any part of our session before the session begins. Dr. Singh 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 Dr. Singh, am responsible for the configuration of any electronic equipment used on my computer which 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 Virginia or Washington DC to be eligible for telepsychiatry services from Dr. Singh.

• I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to his satisfaction before the evaluation.

Additional and In Summary:

Dr Singh offer telepsychiatry services to established patients only via VSee.

- Dr. Singh do not do initial evaluations via the Internet.
- You must be a Virginia or Washington DC resident.
- You must fill out a **telepsychiatry consent form**.
- We must have at least one face to face meeting in my office per year.
- Dr. Singh reserve the right to terminate telepsychiatry services to any patient at any time if he do not feel that it is safe or meets professional standards of care.
- If you are calling me on VSee, at the time of your appointment. If I don't answer, please try again in 2-3 minutes as I may be finishing with my previous patient.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Dr. Singh 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 and authorize Vital Psychiatry Associates- Tejpal Singh MD to use telemedicine in the course of my diagnosis and treatment.

Name of Patient: _____

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

If authorized signer, relationship to Patient: _____

Date: _____