TELEPSYCHIATRY CONSENT

CLEARINSIGHT
PSYCHIATRY, INC.

PLEASE REVIEW THIS NOTICE CAREFULLY BEFORE SIGNING

Telepsychiatry is a form of telemedicine that allows patients to access psychiatric care via interactive audio-video technology. Any electronic communications used will implement network and software security protocols to protect the confidentiality of the patient, and safeguard against intentional or unintentional corruption of identification and imaging data. ClearInsight Psychiatry, Inc utilizes the following HIPAA-compliant encrypted systems: Doximity and Cisco's Webex, both of which are available on iPhone, Android, and PC.

What to Expect:

Telehealth should be considered as an adjunct, rather than a substitute for face-to-face examinations. It is my duty to inform my psychiatrist of any other healthcare providers involved in my care, to supplement my telepsychiatry treatment. I understand there are potential benefits and risks associated with telepsychiatry, as with any medical procedure, and that no outcome can be guaranteed or assured.

Potential Benefits:

- **Improved access to healthcare** by enabling a patient to remain in their local community, and benefit from flexible hours in addition to receiving care in a more comfortable setting
- **Opportunities for mental health specialists to observe** you in your home environment, allowing them to assess your ability to navigate and take care of yourself in your home
- **Efficient psychiatric management**, as mental health professionals can send patients appointment reminders, coping techniques, mental health resources and information over electronic communication systems immediately, as well as effectively coordinate care with other physicians involved in your care

Potential Risks:

- **Synchronous data transmitted is prone to influence from external factors** (e.g. image resolution, bandwidth speed, patient's surrounding environment), and may cause inaccuracy in clinical decision-making
- **Delays in medical attention and treatment** occurring due to deficiencies or failures in telecommunication equipment or software
- **Rare instances where security systems fail**, causing a breach in patients' data
- **Possible lack of comprehensive medical information** may result in adverse drug interactions or allergic reactions

Medical Information Obtained:

I understand any information transmitted via telepsychiatry will be considered part of my medical record, and are subject to the same laws that protect the privacy of my medical information, my right to examine this information, and my right to obtain copies at a reasonable fee. No information identifying me will be disclosed to researchers or other entities without my consent.

Telepsychiatry Authorization:
A variety of alternative methods of psychiatric care are available to me, and I may choose one or more of these at any time. I have the right to opt out of the use of telepsychiatry in the course of my treatment, without affecting my right to future care or continuation of treatment.

My Telehealth Responsibilities:
I acknowledge I have read and understood the information provided above regarding telepsychiatry, and will discuss any lingering concerns I may have, not covered in this document, with my ClearInsight Psychiatry provider. Should I choose telepsychiatry as a method of care, I shall have the following responsibilities:

1. I will not record any telepsychiatry session without the prior written consent of Dr. Liang and Dr. Liang's associates involved in my care.
2. I will inform my ClearInsight provider of any other person or entity within my proximity that may be able to see or hear any part of our remote session before the session begins. Likewise, Dr. Liang will inform me of any entity within her proximity that may compromise the confidentiality of our session.
3. I understand that I **must** be a resident of California to be eligible for telepsychiatry services from ClearInsight Psychiatry, Inc.
4. I understand ClearInsight does not offer telepsychiatry for initial evaluations, and that my first consultation must be in-person, unless extenuating circumstances call for otherwise.
5. I understand my health insurance company may or may not cover services provided over telehealth, and it is my responsibility to pay for services not covered.

Upon signing below, I hereby authorize ClearInsight Psychiatry, Inc to use telepsychiatry in the course of my diagnosis and mental health treatment.

Patient Signature:_____ **Date:**_____

Printed Name:_____

Witness:_____ **Date:**_____