FRONT RANGE PSYCHIATRY

CONSENT TO PARTICIPATE IN TREATMENT BY TELEMEDICINE

1. I understand that telemedicine is different from traditional medicine in that sessions will occur remotely via a HIPAA-compliant video teleconference (VTC) platform. I will become familiar with the technology required for conducting telemedicine sessions and I will conduct all sessions from a private, well-lit location. INITIALS_____

2. I understand that some benefits of telemedicine include increased access to medical care and my personal convenience. I understand that some of the risks include (a) failure of VTC technology such that appropriate medical decision-making becomes impossible and (b) breach of confidentiality due to encryption failure or legal or illegal investigation. INITIALS_____

3. I understand that there may be technical limitations associated with receiving treatment via telemedicine; equipment may fail and my doctor may determine at any time that the quality of the connection is not sufficient to continue. I will provide (and will be provided) a backup telephone number to use in case of VTC failure. INITIALS_____

4. I understand that the laws that apply to the practice of medicine and to the privacy of healthcare information also apply to telemedicine. INITIALS_____

5. I will notify my doctor of my exact location prior to and at the onset of each telemedicine session. I will notify my provider if any other person can hear or see any part of any telemedicine session. It is my responsibility to ensure that my VTC equipment and software are operating properly prior to my appointment. INITIALS_____

6. I understand that as a prerequisite for receiving treatment by VTC, I may be required to visit with my family physician or PCP (and to provide corresponding records) as directed, and/or to obtain laboratory testing. INITIALS_____

7. I understand that even if I am accessing the provider from my own home, my provider may contact police or 911 in the event of a life threatening emergency. INITIALS_____

8. I will not record any VTC session without Dr. Newman's written permission and I understand that Dr. Newman will not record any session without my written permission. INITIALS_____

9. I agree not to obtain controlled substances from other physicians without notifying Dr. Newman. I understand that Dr. Newman may review my prescription history by accessing an online Prescription Drug Monitoring Program at any time. INITIALS_____

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10. I understand that failure to comply with any of the above may result in immediate treatment termination. INITIALS_____

11. Payment for and completion of a telemedicine session is not a guarantee of a prescription; prescriptions are offered only under appropriate clinical conditions determined by Dr. Newman. Prescriptions will not be ordered or refilled following a missed appointment.
INITIALS_____

My questions have been answered to my satisfaction. I understand my alternatives to treatment via telemedicine, which may include traditional outpatient appointments. I understand the risks and benefits of receiving treatment via telemedicine, and I hereby consent to participate in telemedicine. I may revoke this consent at any time. I hereby understand and agree to the above terms & conditions.

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Signature required (Patient or Guardian) Today's Date

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Print Name Date of Birth