Consent to Use Telemedicine

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

28125 BRADLEY RD, STE 220, SUN CITY, CA 92586

PATIENT NAME: _____ DATE OF BIRTH: _____

CURRENT PATIENT LOCATION: _____, CALIFORNIA

I, _____, am physically located in _____, CA. At the beginning of each telemedicine session, I will help Dr._____ to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. Telemedicine and Tele-Mental Health Session are interchangeable in this agreement since this document applies to both Psychiatrist and Therapists sessions.
2. Dr._____ is located in and licensed by the State of California. Dr._____ may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact Dr._____. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273- TALK (8255) for free 24-hour hotline support.
3. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by Dr._____ will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.
4. Dr._____ believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
5. If Dr._____ believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, Dr._____ may discontinue telemedicine services and schedule an in-person consultation with Dr._____ or refer me to a healthcare provider in my area who can provide such services.
6. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with Dr._____.
7. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate

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with Dr._____ and understand there are limitations to the technology which may require an in-person consultation.

8. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with enough lighting and privacy that is free from distractions or intrusions during my telemedicine communications.

9. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by Dr._____ to me will be encrypted during transmission and will be stored only by Dr._____. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

10. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto- remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to Dr._____ and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

11. I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record. Or No part of the encounter will be recorded without my written consent.

12. I agree that I will not record the telemedicine session content in any manner including audio and video, electronic and in any form.

13. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

14. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any question I had with Dr._____ and all of my questions were answered to my satisfaction.

Date:_____ Patient or Guardian's Signature: _____