ProActive Behavioral Services

PSYCHIATRISTS	PSYCHOLOGISTS	THERAPISTS	THERAPISTS
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TELE-PSYCHIATRY-TELE-THERAPY CONSENT FORM

Telepsychiatry and teletherapy provides psychiatric services and counseling/psychotherapy using interactive video conferencing tools, similar to Skype and FaceTime (but more secure and HIPAA compliant), in which the psychiatrist, psychologist, or therapist and the patient are not at the same location.

Telepsychiatry and Teletherapy will allow the patient to receive medical care without the need to visit the office and travel long distance.

Your Rights:

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry and teletherapy.
2. I understand that the software being used (VSee, Zoom, Doxy) is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of VSee at https://vsee.com/hipaa; Zoom; https://explore.zoom.us/docs/doc/Zoom-hipaa.pdf ; Doxy; https://telehealth.org/is-doxy-me-hipaa-compliant/
3. I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any I understand that Proactive Behavioral Services and its practitioners have the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time and to perform face to face visits based upon clinical needs of patients and/or via governing professional requirements.
4. I understand that all rules and regulations which apply to the practice of medicine in the State of Illinois also apply to telepsychiatry and teletherapy.

Your Responsibilities:

1. I will not record any telepsychiatry sessions without the prior written consent of Proactive Behavioral Health provider **and** I understand that Proactive Behavioral Health providers will not record telepsychiatry or teletherapy sessions without my consent;
2. I will inform the Proactive Behavioral Health provider if any other person can hear or see any part of our session before the session begins.
3. Likewise, the Proactive Behavioral Health provider will inform me if any other person can hear or see any part of the session before the session begins. This is so that your privacy can be protected.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry and/or teletherapy, and that you authorize Proactive Behavioral Services and its healthcare providers to use telepsychiatry and/or teletherapy in the course of diagnosis and treatment:

_____ Printed Name

_____ Signature

_____Date

As a Proactive Behavioral Services staff/contracted member, I have explained the Tele-Psychiatry and/or Tele-Therapy procedure to the client/guardian, and I believe they understand.

_____ Staff Signature

_____ Date