TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine at Triangle Psychiatric Services, PA (hereafter referred to as TPS) as part of my psychotherapy and/or medication management. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in North Carolina.

Technology:

I understand that I will need to access an online application to use this platform. I also need to have a broadband Internet connection or a smartphone device with a good cellular connection. I also understand that in case of technology failure, I may contact TPS via phone or email to coordinate alternative methods of treatment.

Financial Obligations:

Fees associated with telemedicine appointments are payable by credit or debit card only. My card will be billed the same day as my scheduled telemedicine appointment. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be and if telemedicine is covered by my plan. I authorize insurance benefits to be paid directly to TPS and that TPS may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for canceled telemedicine appointments in accordance with the TPS cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

Scheduling:

I understand that scheduling is conducted through TPS and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county

crisis line or by dialing 911.

Video/Audio Recording:

As a general practice TPS DOES NOT record telemedicine sessions without prior permission.

Confidentiality:

The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. TPS' telemedicine platform (Doxy.Me) is HIPAA compliant to protect my privacy and confidentiality.

Optional Use of AI-Based Transcription Tools: I understand that TPS may use secure, HIPAA-compliant AI-based tools to assist in clinical documentation (e.g., transcription or summarization of sessions). These tools are only used with my knowledge and consent and are designed to improve the accuracy and timeliness of medical records. All documentation generated with the assistance of these tools is reviewed by a licensed provider before being included in my medical record. I understand that I may decline the use of AI-assisted documentation at any time without impacting the quality or availability of my care.

My Rights:

1. I have the right to withhold or withdraw my consent at any time without affecting my right to future care or treatment.
2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures. Telemedicine-based services may not be as complete as face-to-face services. If my provider believes I would be better served by another form of service, I will be referred to a provider who can offer that care.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed.
4. I understand that TPS may not provide telemedicine services to me if I am outside of the State of North Carolina, and that I may only access telemedicine services from within the State.
5. I understand that I have a right to access my mental health information and copies of medical records in

accordance with North Carolina state law.

I have read and understand the information provided above. I have discussed it with my provider, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

Client Signature: _____ Date: _____

Client Guardian's Signature: _____ Date: _____

Provider's Name & Signature: _____ Date: _____