Dr Torres-Roca Telepsychiatry Informed Consent Form

Do to the public health crisis with the Coronavirus in the area we have decided to offer telemedicine appointment to follow the recommendations of social distancing. This will not be our standard practice and it is a temporary measure.

Telepsychiatry is defined as mental health service provided using electronic, telephone or visual telecommunications.

1. I, the patient or legal guardian of the patient, understand that **Dr Torres-Roca**, currently offers telepsychiatry appointments via phone and visual telecommunication instead of in-office visits while dealing with the Coronavirus outbreak in the area. We offer this visual telecommunication option through the **Doxy.me** platform (which is HIPPA and HITECH protected).

2. I, the patient or legal guardian of the patient, do understand that in the event of a technology failure during a phone and visual telecommunication session immediate steps will be taken by the physician to reconnect. Contact via phone is the first backup step to failed phone and visual telecommunication reconnection. The physician will attempt to reconnect twice (and I will do the same, as well). I, the patient or legal guardian of the patient, will confirm receipt of successful contact. If the allotted appointment time is compromised, the appointment will need to be rescheduled by the patient/legal guardian of the patient to the next available slot. Unless other arrangements are made, the interrupted and rescheduled appointment will be billed.

3. I, the patient or legal guardian of the patient, understand that **Dr Torres-Roca** will not record my visual or phone sessions. I also understand Dr.

Torres-Roca does **not** consent to video or audio recording of the telepsychiatry visits.

4. I, the patient or legal guardian of the patient, understand that the laws that protect the confidentiality of my personal information also apply to telepsychiatry. As such, I understand the information released by me during the session is confidential.

5. I, the patient or legal guardian of the patient, understand that there are risks and consequences from telepsychiatry including, but not limited to the possibility, despite reasonable efforts on the part of Dr Torres-Roca that the transmission of my personal information could be disrupted or distorted by technical failures. I understand that telepsychiatry services may not be as comprehensive as in-person services. This approach is being considered due to the risk/benefit ratio with taking account the public health crisis of COVID-19 and risk of spreading the virus.

6. I, the patient or legal guardian of the patient, understand that in the event of an emergency, and if I cannot reach Dr Torres-Roca, I can call 911 or go to the nearest emergency room.

7. I, the patient or legal guardian of the patient, understand that I have to use the **doxy.me/drtorresroca** to do telemedicine or reschedule my appointment.

8. I, the patient or legal guardian of the patient, understand that the option for telepsychiatry visits is a **temporary** way to address health concerns related to office visits in the setting of the Coronavirus outbreak. Due to Texas Medical Board and private insurance regulations, this option is only

temporary and will **not** become a long-term substitution to in person office visits once the outbreak is contained.

9. I understand that **private insurances** may have different reimbursements or fee schedules for telepsychiatry visits. Many insurances may not cover teletherapy sessions or they only cover it with certain providers/systems. We ask that you please contact your insurance to demand that they cover it do to the circumstances. We will bill your insurance. If they do not cover it, **we will honor the fee you would had paid for an office visit.** However, we would appreciate it if you can contact your insurance and try to get them to approve it.

I have read and understand the above information. By signing this document, I agree to participate in telepsychiatry with Dr Torres-Roca.

Patient Name _____ Date of Birth _____

Patient or if minor, legal guardian's signature: _____

Patient/legal guardian Name:_____

Date:_____