

Carol Paras, M.D., P.A. ---- Telepsychiatry and Electronic Communication Consent Forms- # 3

Initial page one, initial page 2, sign twice on page 3 and sign once on page 4

Tele-psychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:

Convenience, Avoidance of communicable disease and the efficient use of your time (ie. no travel etc.)

The potential risks of telepsychiatry include, but are not limited to:

A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to- face service.

There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.

The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.

A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.

Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

Carol Paras, M.D. utilizes online platforms (Doxy/Zoom) that meet the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

Traditional face-to-face sessions. (**Dr. Paras does not provide face to face sessions.**)

I understand that I have the following rights with respect to telepsychiatry:

- 1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- 2) The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment 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.

Initials: _____

- I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.
- (3) I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist, my condition may not be improve, and in some cases may even get worse.
- (4) I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
- (5) I understand that I have a right to access my medical information and copies of medical records in accordance with New York State Law, Florida State Law and N.J. State Law.

Patient's Responsibilities

- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of New York , New Jersey or Florida , or be in one of those states at the time of the session , to be eligible for telepsychiatry services from Carol Paras, M.D., P.A.
- I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.
- I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to-face visit, or a second telepsychiatry visit.
- I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.

Initials: _____

Patient Consent to The Use of Telepsychiatry with Carol Paras, M.D., P.A.

I, _____, dob _____, hereby consent to engaging in telepsychiatry with Carol Paras, M.D., P.A. as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Patient Name: _____ Date: _____

Signature: _____

Patient Consent to the use of Electronic/and Telephonic Communication with Carol Paras, M.D., P.A.

Texts are not- encrypted; some email is and some is not. I rarely communicate via email.. or fax but sometimes it is necessary.. I do not read emails quickly.....This is not the preferred or quickest way for us to way to communicate. Fax # is 561-961-0082

However, there are times emails is essential.

For –Registration forms and consents, annual medical updates or policy changes

IF- I must send you or you must send me a letter or a form for a third party, and you do not have a fax machine.

I use Proton Mail which is purportedly encrypted. I also use a mac computer which is also very secure but anything can be hacked by a sophisticated criminal. I CHECK THIS EMAIL infrequently, so please alert me by text if you are sending me an email. The email address that I use is **drcarolparas@protonmail.com**

I may also use email to send you :

Information on new medications- to include more than we have spoken about in a session, and signs and symptoms to watch for, for your easy reference at home. Transmitting education materials. Sending referral information.

I may also communicate on your behalf to receive or send info to other doctors involved in your care

Email is susceptible to confidentiality breaches. Even if you take precautions, it may still be easily read by others.

Be sure that no one has access to your email account. It is preferable for you to not use your business email.

I cannot account for nor be responsibility for the email practices of other doctors, offices or agencies, receiving your PHI.

If you have something more to discuss with me then you must make an appointment. NEVER USE EMAIL FOR AN URGENT OR EMERGENCY SITUATION! And, again, alert me by text if you had to send something by email!

Emails are only accepted from established patients

What are the risks of using email? This is not an exhaustive list

- Email may be seen by unintended viewers if addressed incorrectly
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters
- **SPECIAL NOTE: Emails are discoverable in litigation and may be used as evidence in court.**

I will and must let Dr, Paras know immediately if my email address changes.

- If I do not receive a response from Dr. Paras in 48 hours, I will contact her by telephone if a response is needed.
- I will use email communication only for the purposes stated above.
- I will advise Dr. Paras in writing should I decide that I would prefer not to continue communicating via email

Your Preferred email _____

Signature _____ . Date _____

Printed name _____

Patient Consent to the use of Text Messages to/from Carol Paras, M.D., P.A.

NOTE: Text messages are not encrypted or protected in any way

Do you consent to receiving text messages from Carol Paras, M.D., P.A. about appointments?

Yes _____ . No _____

Preferred number _____

Do you consent to receiving other text messages regarding prescriptions or any other matter?

Yes _____ . No _____

Preferred number _____

Phone Messages- May or may not be confidential depending on who may have access to your phone

Do you consent to phone messages being left on your phone or answering machine?

Yes _____ No _____

Preferred number _____

Do you consent to anyone else receiving messages on your behalf? If so whom, what is their relationship to you, and be explicit about what type of messages can be sent to them, Give their names, dob and phone number...

If you have provided a home phone – note messages will be left there if you are not available in a timely manner on your cell phone. If that is not acceptable initial here _____

Signature _____ **Date** _____

Printed name _____

