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Telehealth Informed Consent Form

Telehealth or telepsychiatry is the delivery of psychiatric services to address a patient's psychiatric needs, using interactive electronic communications systems, where the psychiatrist and the patient are not in the same physical location. Telehealth will occur primarily through HIPAA compliant interactive audio, video, telephone and/or other audio/visual communications.

As per current guidelines, clinicians need to be licensed in the state where the patient they are seeing is located. Dr. Gulwadi currently has a medical license in the state of Michigan. States determine whether and under what circumstances a healthcare provider is authorized to provide services in the state, including whether services can be provided during an emergency without a license from that state. Telepsychiatry Benefits: Increased accessibility to psychiatric care. Patient convenience.
Potential Telepsychiatry Risks: Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist. Delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment. Security protocols can fail, causing a breach of privacy of my confidential medical information. In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions

By signing this document:

1. I understand that telehealth services may include evaluation, consultation, treatment planning, as well as psychological counseling. I understand the above-mentioned benefits and risks associated with telehealth. In addition, I understand that telehealth- based services may not be as comprehensive as in-person services.
2. I understand that the laws that protect the confidentiality of my personal and medical information also apply to telehealth. I understand there are legal exceptions that include, but not limited to child or adult abuse, court orders or subpoena or danger to self or others.
3. I understand that I have the right to withhold or remove consent for tele health at any time without affecting my right to future care or treatment. I understand that my psychiatrist has the right to withhold or withdraw her consent for the use of telepsychiatry at any time during the course of my care.
4. I understand that certain situations including emergencies and crises are inappropriate for audio, video and/or computer-based psychological or psychiatric services. If I am in crisis or I am experiencing a medical or psychiatric emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. I understand that emergency situations may include having serious thoughts about hurting or harming myself or others, having uncontrolled psychotic or manic symptoms, experiencing a life threatening or emergency situation, abusing drugs or alcohol or experiencing other concerns which may present a risk to my safety.
5. I understand that I must be physically within Michigan to be eligible for telepsychiatry. I will inform my psychiatrist as soon as my session begins of my physical location.
6. I understand that my psychiatrist can send prescriptions for medications only to Michigan pharmacies or addresses.
7. I agree to ensure the proper configuration and functioning of all my electronic equipment prior to my session including making sure it has a working camera and audio input so that my psychiatrist can see and hear me in real time.
8. I understand that I am responsible for finding a private and quiet location where my session may be conducted uninterrupted. I will ensure the confidentiality of my internet or Wi-Fi connectivity and the security of my electronic device.
9. I agree to not record any telepsychiatry sessions without written consent from my psychiatrist. I understand that my psychiatrist will not record any of our telepsychiatry sessions without my written consent.
10. I agree to inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session.
11. If I lose my connection during a session, I will contact my psychiatrist and try to reconnect on the telehealth set up. If the connection is lost and session cannot be completed on audio and visual communication platform, I will call Ashwini Gulwadi PLLC to complete the session on phone call or schedule a new appointment. I understand that I am responsible for payment for the session when the appointment could not be completed due to my connection issues.

I hereby give my consent for the use of telepsychiatry in my medical care and authorize my psychiatrist to use telemedicine in the course of my diagnosis, medical decision making and treatment. I agree to hold Ashwini Gulwadi, PLLC or Dr. Gulwadi harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

I have read and understand the above information and agree to participate in telehealth services with Ashwini Gulwadi, PLLC and Ashwini Gulwadi, MD.

Client/ Patient Name: _____

Client/ Patient Signature: _____Date: _____