# TELEHEALTH VIDEO-CONFERENCING CONSENT FORM

1. **I _____am a patient of Dr. Louis E. Kopolow.**

2. **Dr. Kopolow, having completed a psychiatric evaluation and having established a therapeutic, doctor-patient relationship, is offering to conduct sessions using telehealth technology. This is the delivery system of services using videoconferencing where the patient and the doctor are not in the same location.**

3 **The video conferencing system will be of Dr. Koplow's choosing, taking into consideration connectivity. The systems meet HIPAA standards of encryption and privacy, noted per the Medical Society. For circumstances outside of Dr. Kopolow's control such privacy may not be absolute.**

4. **I understand the benefits of video conferencing such as easier access to care and reduction of such barriers as traffic, illness exposure or travel time. Dr. Kopolow and I have discussed the benefits of this mode of care for my particular needs.**

5. **I understand that Dr. Kopolow is licensed to practice medicine in Maryland.**

6. **I understand the shortcomings. requirements and hazards of video conference may include**
   - **a . Encryption may not be fool proof.**
   - **b. There can be a disruption of signal or transmission at any time. If that occurs the session can continue by telephone. If this occurs too frequently for videoconferencing to be practical, Dr. Kopolow will discuss alternatives.**
   - **c. Non-verbal cues of communication may be lost.**
   - **d. I will need to choose a private location in my home or workplace, where I will reduce the chance of being over-heard. Dr. Kopolow cannot guarantee I will have the same privacy as I do in his office. I may further reduce inadvertent disclosures of information by wearing headphones.**
   - **f. I am responsible for checking with my insurance company to determine coverage for tele-psychiatry. Dr. Kopolow will apply the applicable suffixes to the services on my bill.**
   - **g. I am responsible for payment of private-pay fee on the day of my visit.**
   - **h. If Dr. Kopolow determines that I pose an imminent danger to myself or others, Dr. Kopolow will contact the necessary authorities. I will provide Dr. Kopolow with the name and phone number of an emergency contact person and will give him written permission to contact that individual if he reasonably believes I am in danger or crisis and may not be able to help myself. The name of my emergency contact is_____. The phone number of this contact is _____.**

     **I also understand I may need to seek in-person mental health services with a local crisis center or emergency room should video conferencing be insufficient to address my needs.**
   - **j. If Dr. Kopolow or I believe that videoconferencing does not serve my needs, we will review alternatives including in person sessions, transfer to another clinician or to a higher level of care.**

7. **I understand Dr. Kopolow will re-assess in-person meetings when the conditions necessitating videoconferencing have abated. The option of continuing videoconferencing appointments will be explored at that time.**

8. **In between sessions, if I require assistance, I may contact Dr. Kopolow leaving a non-urgent message by calling the office phone (301-963-0060 ) or our answering service after hours (1-866-557-5696) or through email at admin1@pgpmd.com.**

**Charges for these between session appointments will be billed based on the length of these sessions.**

**By signing this agreement, I declare I have read this document and have had questions answered to my satisfaction. I give my permission that my emergency contact individual be alerted if Dr. Kopolow reasonably believes I pose(s) a danger to myself or others and am/is unable to help myself.**

_____ _____

**Patient Signature** **Date**