Ichange Counseling & Psychiatry Dorian Aponte, MD
www.ichangetx.com 940-448-0304

Telepsychiatry/ Teletherapy Informed Consent Form

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

I, the patient, understand that Ichange Counseling & Psychiatry currently offers telepsychiatry or teletherapy appointments via phone and visual telecommunication as an alternative to in-office visits. We offer this visual telecommunication option through the Doxy.me platform (which is HIPPA and HITECH protected). I fully understand that if I choose a different platform for communication it may not be HIPAA protected.

• I understand payment is paid prior to tele session.

Technology Failure: I, the patient, do understand that in the event of a technology failure during a phone or visual telecommunication session immediate steps will be taken by the physician / provider to reconnect. Contact via email or by phone is the first backup step to failed phone and visual telecommunication reconnection. The provider will attempt twice (and I will do the same, as well). I, the patient, will confirm receipt of successful contact.Please have phone with you that you shared number to on intake doc.

_____I understand that Ichange will not record my visual or phone sessions, unless there is an explicit written consent by me for reasons that clearly benefit my treatment. I also understand Dr. Aponte / Ichange provider does **not** consent to video or audio recording of the telepsychiatry visits.

_____I understand that in the event of an emotional emergency, and I cannot reach provider of Ichange, I can call 911 or local emergency response team, go to the nearest emergency room, or contact National Suicide Prevention Lifeline at: 1-800-273-8255

_____ I understand that I have the option to choose the methods of telecommunications that I prefer and that I must "opt in".
___ Doxy.me or other hippa compliant video ___ Phone (MARK BOTH IF COMFORTABLE)

_____I give my consent to use electronic devices and programs for office visits.___I understand Telehealth is not provided across state lines. Patient / Client must physically be in Texas during telehealth sessions.

_____I understand that the option for telepsychiatry/ Teletherapy 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 might be temporary.

_____I understand that private insurances may have different reimbursements or fee schedules for telepsychiatry / teletherapy visits. I will be fully responsible for the cost of the visit if it is not covered by my insurance plan. Many insurances may not cover teletherapy sessions. It is my responsibility to call my insurance carrier and confirm coverage of my visit costs.

* CONSENT: I give my consent to use the telephone for my distance counseling.
• I have had ample opportunity to ask questions and receive clarification about these options and this policy.
• I will comply with the above plans set up to address the potential risks of telepsychiatry and discuss any aspects that require my participation in the planning.
• I understand that I have the option to choose which telecommunication method(s) I prefer.
• I have "opted in" for the electronic technology that is acceptable to me at this time.
• I understand that I have the option to change my mind about any of my choices listed above and I will do so in writing.
• I do recognize the potential risk of compromise to my confidentiality by using phone or visual telecommunication.
• I wish to proceed knowing these risks and understand I should not be driving during a tele session. I Understand if I feel unsafe or are in an emergency I will call 911.

I consent to all office fees, policies, and procedures. I understand HIPAA, my rights, and consent to being in treatment with Ichange Counseling & Psychiatry.

_____ _____

Signature Name and Date