Columbia Psychiatry

Telepsychiatry Consent Form

I understand that telepsychiatry is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual who is in a different location from the psychiatrist.

I understand that I must be physically in Missouri to be seen by any provider at Columbia Psychiatry, due to state licensure requirements.

I understand that the laws that protect patient privacy and the confidentiality of medical information, including HIPAA laws, also apply to telepsychiatry.

I understand that I am responsible for the security and privacy of my location during telepsychiatry visits.

I understand that any recording of telehealth sessions by any means, audio and/or visual, is strictly prohibited by either Columbia Psychiatry or the patient. Recording of telehealth sessions violates privacy and confidentiality and may be grounds for termination of services.

I agree to inform my Columbia Psychiatry provider of anyone else who is present for my telepsychiatry visit before the visit begins.

I understand that if I choose to submit a telepsychiatry visit to my insurance for reimbursement, the amount of reimbursement may be less, or my insurance company may choose not to reimburse for telepsychiatry visits.

I understand that my provider may decide that telepsychiatry is not appropriate for me, and may require me to be seen in person.

Patient's Signature: _____Date:_____

Provider's Signature: _____Date: _____

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