**Tele-Psychiatry Contact & Informed Consent**

(PLEASE READ THIS DOCUMENT CAREFULLY)

**Introductions:**

Sessions and visits will be held via “tele-psychiatry”: using audio/video conferencing software and/or a separate software device for audio or video (i.e telephone, headset, computer etc). Tele-Psychiatry establishes a formal physician-patient relationship used to maintain regular assessment, diagnostics, therapy, and/or prescription.

This document serves as a consent form for treatment via tele-psychiatry in general.

**Consent (PLEASE READ CAREFULLY BEFORE INITALING):**

1) The patient understands that he/she is consenting to behavioral health evaluation and treatment via tele-psychiatry.

2) The patient understands that no results can be guaranteed, despite our best efforts to deliver care.

3) The patient understands that they are able to ask questions about tele-psychiatry or any aspects of the evaluation and treatment at any time.

4) The patient understands that in order to continue tele-psychiatry sessions, no patient, by any means is allowed to participate in operating any motor vehicle, and/or heavy machinery, as this will result in termination of your tele-psychiatry sessions.

5) The patient understands that he/she should be a place where they are able to discuss any private medical issues freely as necessary with their provider with no limitations or distractions.

6) the patient is responsible of carefully reading the instructions on how to setup a tele-psychiatry account and test it prior to their appointment.

7) The patient is responsible for having a credit/debit card saved on our system, so we are able to run the payment per insurance prior to your appointment.

By signing below, I hereby authorize disclosure of information in the medical record of the patient identified below which includes information that may be stored in a paper and /or another electronic format. Such record may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS; AIDS related treatment; sexually transmitted diseases or infections; venereal disease; tuberculosis; hepatitis. Disclosure shall be limited between the listed entities and to the information obtained during course of treatment.

I certify that I have read and understand the entirety of this document. By signing below, I am agreeing with all the points addressed in this document, put forward by ACESO, and I am also authorizing ACESO to use tele-psychiatry for my evaluation and treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_