Patient Information Form

please send photo ID and Medicare cards if applicable

Name:_____ Date:_____

Birth Date: _____ Age: _____ Sex:_____ Pronouns:_____

Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone _____

Employer Name: _____Work Phone: _____

Email Address:_____

Preferred Method of contact: (email, home, work)_____

*Appointment reminders will be sent out one week and one day before appointment, via email/text so please provide an email/text in which this can be securely transmitted.

Marital Status: S M W D Partner
Spouse/Partner Name _____
Phone Number:_____

Emergency Contact Information:
Nearest Relative not living with you, whom we may contact in case of emergency:
Name:_____
Relationship:_____ Phone Number:_____
Presenting\Problems/Complaints:_____

MEDICAL HISTORY Please explain any significant medical problems, symptoms, or illnesses/hospitalizations or rehab:_____
_____
_____

Current Medications: _____
_____
_____

Credit Card Consent Form

Patient Name_____

Name on Card if Different_____

I authorize Alexandra Whiddon/Atlanta Integrative Psychiatry, to charge my credit card for professional services. This consent will apply to any future cards that I may give to SET psych via phone/email/text.

All professional services including: office sessions/ phone/video consults, missed appointments, and form preparation. Missed appointments will be automatically billed for $50.00 if appointment not cancelled 24 hours prior to scheduled appointment. _____(Initial)

Credit Card Number_____

CVV Number (3 digit number in italics on BACK of credit card or 4 digit for AMEX)
_____

Expiration Date:_____

Card Holder's Billing Zip code _____

Email to send receipts_____

Card Holder Signature _____
Date _____/_____/_____

Southeastern Telepsychiatry
Alexandra Whiddon, APRN-BC
1 Diamond Causeway, Suite 119
Savannah, Georgia 31406

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: *Southeastern Telepsychiatry* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *Southeastern Telepsychiatry* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *Southeastern Telepsychiatry* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *Southeastern Telepsychiatry* would use and/or disclose your PHI. Use of PHI means when *Southeastern Telepsychiatry* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *Southeastern Telepsychiatry* releases, transfers, gives, or otherwise reveals it to a third party outside of the *Southeastern Telepsychiatry* With some exceptions, *Southeastern Telepsychiatry* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *Southeastern Telepsychiatry* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *Southeastern Telepsychiatry* Please note that *Southeastern Telepsychiatry* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *Southeastern Telepsychiatry* has created or maintained in the past and for any of your records that *Southeastern Telepsychiatry* may create or maintain in the future. *Southeastern Telepsychiatry* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *Southeastern Telepsychiatry* Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: ***Southeastern Telepsychiatry*** will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *Southeastern Telepsychiatry* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *Southeastern Telepsychiatry* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *Southeastern Telepsychiatry* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *Southeastern Telepsychiatry* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: *Southeastern Telepsychiatry* may use and disclose your PHI to bill and collect payment for the treatment and services *Southeastern Telepsychiatry* provided to you. Example: *Southeastern Telepsychiatry* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *Southeastern Telepsychiatry* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *Southeastern Telepsychiatry*

office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *Southeastern Telepsychiatry* will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to *Southeastern Telepsychiatry* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *Southeastern Telepsychiatry* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *Southeastern Telepsychiatry*

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *Southeastern Telepsychiatry* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – YOUR NAME may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *Southeastern Telepsychiatry* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *Southeastern Telepsychiatry* may make a disclosure to the appropriate officials when a law requires *Southeastern Telepsychiatry* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *Southeastern Telepsychiatry* may disclose information about you to respond to a court or administrative order or a search warrant. *Southeastern Telepsychiatry* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *Southeastern Telepsychiatry* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *Southeastern Telepsychiatry* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *Southeastern Telepsychiatry* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *Southeastern Telepsychiatry* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *Southeastern Telepsychiatry* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *Southeastern Telepsychiatry* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), *Southeastern Telepsychiatry* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *Southeastern Telepsychiatry* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *Southeastern Telepsychiatry* has a reasonable suspicion of child abuse or neglect, *Southeastern Telepsychiatry* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *Southeastern Telepsychiatry* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *Southeastern Telepsychiatry* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *Southeastern Telepsychiatry* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *Southeastern Telepsychiatry* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. **Military and Veterans:** If you are a member of the armed forces, *Southeastern Telepsychiatry* may release PHI about you as required by military command authorities. *Southeastern Telepsychiatry* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *Southeastern Telepsychiatry* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *Southeastern Telepsychiatry* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *Southeastern Telepsychiatry* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *Southeastern Telepsychiatry* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *Southeastern Telepsychiatry* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *Southeastern Telepsychiatry* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *Southeastern Telepsychiatry* compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *Southeastern Telepsychiatry* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *Southeastern Telepsychiatry* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *Southeastern Telepsychiatry* in writing of your decision. You understand that *Southeastern Telepsychiatry* is unable to take back any disclosures it has already made with your permission, *Southeastern Telepsychiatry* will continue to comply with laws that require certain disclosures, and *Southeastern Telepsychiatry* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *Southeastern Telepsychiatry* possession, or to get copies of it; however, you must request it in writing. If *Southeastern Telepsychiatry* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *Southeastern Telepsychiatry* within 30 days of receiving your written request. Under certain circumstances, *Southeastern Telepsychiatry* may feel it must deny your request, but if it does, *Southeastern Telepsychiatry* will give you, in writing, the reasons for the denial. *Southeastern Telepsychiatry* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *Southeastern Telepsychiatry* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *Southeastern Telepsychiatry* limit how it uses and discloses your PHI. While *Southeastern Telepsychiatry* will consider your request, it is not legally bound to agree. If *Southeastern Telepsychiatry* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

You do not have the right to limit the uses and disclosures that *Southeastern Telepsychiatry* is legally required or permitted to make.

3. The Right to Choose How *Southeastern Telepsychiatry* Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *Southeastern Telepsychiatry* s obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *Southeastern Telepsychiatry* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

Southeastern Telepsychiatry will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *Southeastern Telepsychiatry* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *Southeastern Telepsychiatry* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *Southeastern Telepsychiatry* receipt of your request. *Southeastern Telepsychiatry* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *Southeastern Telepsychiatry*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *Southeastern Telepsychiatry* denial will be attached to any future disclosures of your PHI. If *Southeastern Telepsychiatry* approves your request, it will make the change(s) to your PHI. Additionally, *Southeastern Telepsychiatry* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *Southeastern Telepsychiatry s* Director and Privacy Officer, Alexandra Whiddon, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision ***Southeastern Telepsychiatry*** made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. ***Southeastern Telepsychiatry*** will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. *Southeastern Telepsychiatry* **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

• The day-to-day healthcare operations of the practice.

• Patients files are stored on a cloud EMR that is HIPAA compliant.

• The practice uses a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by confidentiality rules of HIPAA.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

Consent For Treatment

My Responsibilities to You as Your Provider:

I. Confidentiality With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your treatment.. I cannot and will not tell anyone else what you have told me, or even that you are in treatment with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a session with you.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

4. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board. I would inform you before taking this step. If you are my client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.

II. Other Rights

You have the right to ask questions about anything that happens in treatment. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right provider for you. You are free to leave treatment at any time.

My Training and Approach to Therapy I have a Masters in Nursing from Vanderbilt University, earned in August 2000. I have a Family Psychiatric and Mental Health Nurse Practitioner Certification form the ANCC as well as a Child and Adolescent Psychiatric and Mental Health Clinical Nurse Specialist Certification form the ANCC. I am licensed in the state of Georgia as a CNS/PMH. I am also licensed in the state of Florida as an PMHNP. I believe in an integrative approach to psychiatry. I will focus on the mind body connection, diet, and exercise. I also will explore pharmacology options that I think may be beneficial to your treatment. I can also work closely with your therapist to establish the best treatment options available for you.

A nurse practitioner in the state of Georgia/Florida may prescribe under a collaborative agreement with a designated psychiatrist. Due to the collaborative nature of my practice, the doctor I collaborate with is available for consult at any time regarding your case. He/She will also evaluate your records based on state protocol.

If I feel that your treatment is outside my scope of practice, I will refer you directly to another provider that I feel is suited for your individual circumstances. Treatment usually ends after an agreed upon termination date. If I have not had an appointment with you in over 6 months, it will be considered that you have terminated treatment.

If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for treatment..

I am away from the office several times in the year for extended vacations or to attend professional meetings. If I am not taking and responding to phone messages during those times I will have someone cover my practice. You will be informed of my absences and detailed messages will be left on my answering machine about who to contact during these absences. I am available for brief between- session phone calls and/or electronic communication (email/text).

Your Responsibilities as a Client

You are responsible for being available for your sessions at the allotted times, and at the time we have scheduled. Please know that I try very hard to be as prompt as possible, but please leave 15

minutes leeway for appointment start times. You are responsible for paying for your sessions at the agreed upon rate, on the date of service. The only payment accepted is credit card.

I look forward to working with you, please feel free to contact me with any questions or concerns.

Client Consent to Treatment I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law.I understand the security risks involved with using email/text and will hold the provider harmless and not liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. I understand my rights and responsibilities as a client, and my providers responsibilities to me. I understand that I the use of medication in treatment comes with risks that have been explained to me, and I will ask any questions about medications that I have prior to or during treatment. I understand the collaborative relationship of Alexandra Whiddon, APRN and her collaborative physician. I am also accepting the inherent risk of text/email as described above.

I agree to undertake treatment with Alexandra Whiddon, APRN. I know I can end treatment at any time I wish and that I can refuse any requests or suggestions made by Ms. Whiddon. I am over the age of eighteen.

Signed:_____
Date:_____

Telepsychiatry Consent

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual systems where the provider and the patient are not in the same physical location. The interactive systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and aid in protecting against intentional or unintentional corruption.

Potential Benefits:

• Increased accessibility to psychiatric care

• Patient convenience

Potential Risks:

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

• Information transmitted may not be sufficient (poor resolution video) to allow for appropriate medical decision making.

• Ms. Whiddon may not be able to arrange for emergency care that I may require.

• Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

• Security protocols can fail, causing a breach of privacy of my confidential medical information.

• A lack of access to all the information that might be available in a face to face visit but not in telepsychiatry may result in errors in medical judgment.

Alternatives to the use of telepsychiatry:

• Traditional face to face session with Alexandra Whiddon, APRN.

My rights:

• I understand that the laws that protect my privacy and confidentiality of medical information also apply to telepsychiatry.

• I understand that the technology that Ms. Whiddon uses (ie:Skype) may or may not be encrypted to prevent the unauthorized access to my private medical information.

• I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any further care or treatment.

• I understand that Ms. Whiddon has the right to withhold or with draw her consent for the use of telepsychiatry during the course of my care at any time.

• I understand that all rules and regulations, which apply to the practice of medicine and nursing in the state of Georgia, also apply to telepsychiatry.

My Responsibilities:

• I will not record any telepsychiatry session without written consent from MS. Whiddon. I understand that Ms. Whiddon will not record any of our telepsychiatry session without my verbal or written consent.

• I will inform Ms. Whiddon if any other person can hear or see any part of our session before the session begins.

• Ms. Whiddon will inform me if any other person can hear or see any part of our session before the session begins.

• I understand that I, not Ms. Whiddon, am responsible for the configuration of any electronic equipment used on my computer, which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

• I understand that I must be a resident of the state of Georgia to be eligible for telepsychiatry services from Ms. Whiddon.

• I understand that I may have to verify my identity to Ms. Whiddon’s satisfaction before the evaluation.

Security measures used by the Provider:

As stated above, communicating via internet does come with privacy risk. While the provider cannot guarantee total confidentiality, Ms. Whiddon has and will use reasonable safeguards to protect your health care information as required by law.

Hold Harmless:

I agree to indemnify and hold harmless Ms. Whiddon, and her corporation, Atlanta Integrative Psychiatry, other agents of her corporation, and providers and suppliers of technology from and against all losses, expenses, damages and costs, including reasonable attorney fees, relating to or arising from any information loss due to technical failure, encryption failure, or viruses.

Patient Consent:

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Ms. Whiddon and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Alexandra Whiddon, APRN to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient or Authorized Person Signing for patient_____

Relationship to Patient (if signer other than patient)_____

Date:_____

Patient Email and Text Message Informed Consent

You may give permission to AIP/SET to communicate with you by email and text message. This form provides information about the risks of the forms of communication, guidelines for email/text communication, and how I use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1) How we will use email and text messaging:

Due to my concierge style of practice, I use these methods of communication for speed of communication. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. I will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to the Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

2) Risk of using email and text messages:

The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to the following:
a) Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Senders can easily misaddress an email or text and send the information to an undesired recipient.
c) Backup copies of emails and texts may exist even after the sender and/or recipient has deleted his or her copy.
d) Employers and online services have a right to inspect emails and texts sent through their company systems.
e) Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f) Emails and texts can be used as evidence in court.
g) Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

2) Conditions of the use of email and text message:

AIP/SET cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. I do not use an encrypted method of communication.

You must acknowledge and consent to the following conditions:
a) IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911/988.
b) Emails/Texts should be responded to within 24 hours. If they haven't been responded to please call my office to follow up on email/text. You should speak to me directly by phone to discuss complex and/or sensitive situations rather than send email or text messages if you have any privacy concern.
d) Email and text messages may be filed electronically into your medical record.
e) Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
f) You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information.
g) AIP/SET is not liable for breaches of confidentiality caused by you or any third party.
h) It is your responsibility to follow up with AIP/SET if warranted.

3) Withdrawal of consent:

I understand that I may revoke this consent at any time by so advising AIP/SET in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am entitled.

4) Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between AIP/SET and me, and consent to the conditions and instruction outlined, as well as any other instructions AIP/SET may impose to communicate with me by email or text message. I understand that these are unencrypted forms of communication. I consent to also receiving appointment reminders by email/text.

Email: _____ Cell: _____

Patient Name: _____

Signature: _____ Date:_____