YOUTH CONSULTATION SERVICE, INC.
284 Broadway, Newark, NJ 07104
Tel. (973) 482-8411

CLIENT INFORMATION AND INFORMED CONSENT FOR TELEPPSYCHIATRY SERVICES

Telepsychiatry is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the client are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect client information and safeguard the data exchanged.

1. Requirements:
   - A computer, laptop, tablet or mobile device with access to internet.
   - Access to the URL or App to schedule and/or accept scheduled appointments.

2. Potential Benefits:
   - Telepsychiatry provides convenience and increased accessibility to psychiatric and therapeutic care for clients who are unable to be treated face to face.
   - Telepsychiatry allows for increased coordination of care for treatment team members.

3. Potential Risks:
   - Information transmitted may not be sufficient due to technical difficulties which could interfere with medical decision making by the Psychiatrist, Psychiatric APN, or Clinician.
   - The provider may not be able to provide treatment to the client using electronic equipment nor provide for or arrange for emergency care the client may require, in cases of connection failure.
   - Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
   - Although highly unlikely, even with HIPAA compliant telehealth platforms – security protocols can fail, causing a breach of privacy/confidentiality.
   - A lack of access to all the information that might be available in a face to face visit but not in the telepsychiatry session may result in errors in medical judgment.
   - In the event that a group session is being provided via telehealth, client confidentiality may be at risk if members of the group do not comply with Group Norms discussed at the beginning of each session.

4. My Rights:
   - I understand that the laws that protect the privacy and confidentiality of health information also apply to telepsychiatry.
   - I understand that the technology utilized by the provider is encrypted to prevent unauthorized access to my private information.
   - I understand that I have the right to be made aware of the location of the Provider at the time of the telepsychiatry session.
   - I have the right to withhold or withdraw my consent to the use of telepsychaitry during the course of my care at any time. I understand that my withdrawal of consent will not affect my future care or treatment.
   - I understand that the provider has the right to withhold or withdraw the use of telepsychiatry during the course of my care at any time.
   - I understand that all rules and regulations in the State of New Jersey that apply to the scope of services being received also apply to telepsychiatry.

- I understand that the provider will not record any of our telepsychiatry sessions without my written consent.
- I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.
- I understand that my confidentiality may be at risk when attending a group session on a telehealth platform, if other group members do not follow the Group Norms outlined at the beginning of each session.

5. My Responsibilities:
   - I will not record any telepsychiatry sessions on any device without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
   - I understand that I, not the provider, am responsibility for providing and configuring 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 and agree to revert to a telephone voice session utilizing the indicated backup telephone number below should a video connection not function properly.
   - I have read and understand that all YCS policies apply to all telepsychiatry sessions as well as face to face visits.
   - I understand that I agree to be seen face to face at least once a year to maintain therapeutic services and provider/client relationship.
   - I understand that I must establish a therapeutic relationship with my proposed telepsychiatry provider at YCS face to face prior to beginning telepsychiatry treatment.
   - I consent to paying fees that are the same as face-to-face appointments.
   - I understand that if I am attending a group telepsychiatry session, that no other person(s) should not be able to hear or see the group session other than the approved members of the group.

CLIENT CONSENT AND SIGNATURE PAGE

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my psychiatric and medical care and authorize the provider to use telepsychiatry in the course of my diagnosis and treatment.

______________________________ ______________________________

Print Client's name *Signature of Client*

Dated:______________________________

If the Client is a minor (a person under 18 years of age) and does not qualify to sign this Informed Consent on his or her own under the circumstances described in footnote 1 below, then this Consent must be signed by the Client's Legal Representative:

____

Signature of Legal Representative

Dated:______________________________ ______________________________

Print relationship of Legal Representative to Client and authority to act on behalf of Client

Client Email: ______________________________

Client telephone contact: (______)______-_________

Client Back-up- telephone contact: (______)______-_________

Alternate contact: (______)______-_________