**Norman Psychiatry**

**Informed Consent for Telemedicine Services**

**Introduction**

Telemedicine involves the use of electronic communications to enable health care providers to share individual patient medical information, for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

* Patient medical records
* Medical images
* Live two-way audio and video
* Output date from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

* Improved access to medical care by enabling a patient to remain in his/her location
* More efficient medical evaluation and management
* Obtaining expertise of a provider in areas that are underserved

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These include:

* In rare cases, information transmitted may not be sufficient to allow appropriate medical decision-making by the provider
* Delays in medical evaluation and treatment could occur due to difficulties or failures with equipment
* In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

**Tips for a Successful Telemedicine Visit**

* Check your internet connection
* Make sure your audio and video (webcam) is working
* Find a quiet, private location if possible
* Check your lighting
* Write down problems and questions ahead of time
* Dress appropriately for the visit

**Scheduling your Telemedicine Appointment**

* A Norman Psychiatry Associate will contact you with an available appointment date and time
* An email with Telemedicine Services information, directions, and consent will be emailed to you; please read, sign, and either:
	+ fax to (405) 579-4223
	+ email back to us at info@normanpsychiatry.com
	+ drop off or mail to our office 2201 Westpark Drive, Norman, OK 73069
	+ if you are unable to get this form back to us, we can take a verbal consent during your visit as a last resort
* The email will include a link to click on for access to your telemedicine appointment, **do not click the link or check in for the appointment** until a few minutes before your appointment
* A Norman Psychiatry Associate will contact you the day before your appointment to confirm the appointment, collect your credit card information for payment if you owe anything for the appointment (the card will not be charged until the day of the appointment), and take verbal consent for services over the phone if needed

**Logging in to your Telemedicine Visit**

* **You MUST use GoogleChrome, Firefox, or Safari.** These browsers allow for your mic and camera to work properly. You can easily download any one of these browsers from the internet.
* Instead of clicking on the link provided to your email, another option is to enter the web address with the correct provider’s name in your browser as listed below:

Dr. Ripperger www.doxy.me/drripperger

Dr. Raju www.doxy.me/Draraju

Amy Boggs [www.doxy.me/amyboggs](http://www.doxy.me/amyboggs)

Nicole Bush www.doxy.me/bush34

Laura Hall www.doxy.me/LHall616

Shannon Dukes www.doxy.me/Dukeslpc

Kari Workman www.doxy.me/kworkmanwaitingroom

Rock Richardson www.doxy.me/mrrichardsonlpc

Bob Moore www.doxy.me/bobmoorelpc

Brooke Braziel www.doxy.me/brookewaitingroom

* Please ensure that your microphone and webcam are enabled and functioning upon logging in
* Enter your name and click “Check In”
* You will appear in the provider’s que as “Arrived” and your appointment will begin promptly, please wait for your provider to start the video call

**Norman Psychiatry**

**Informed Consent for Telemedicine Services**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Purpose: The purpose of this form is to obtain your consent to participate in a telemedicine consultation.
2. Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit.
3. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine visit, and all existing confidentiality protections under federal and Oklahoma State law apply to information disclosed during this telemedicine visit.
4. Rights: You may withhold or withdraw consent to the telemedicine visit at any time without affecting your right to future care or treatment.
5. Disputes: You agree that any dispute arriving from the telemedicine visit will be resolved in Oklahoma, and that Oklahoma law shall apply to all disputes.
6. It is important to use a secure internet connection rather than public/free Wi-Fi.
7. It is important to be on time. If you need to cancel or change your telemedicine appointment, you must notify the office at 405-579-4111. 24 hours notice is expected or you could be charged a fee.
8. If you are not 18, we need the permission of your parent or legal guardian.
9. Payment of Services: You agree that Norman Psychiatry, APRN-CNP, PLLC, reserves the right to bill a telemedicine visit to your respective insurance company. As well, you are responsible for any patient portion of the telemedicine visit, before your visit will take place. You should confirm with your insurance company that the video session will be reimbursed, if they are not, you are responsible for full payment.
10. Risks, Consequences, and Benefits: You have been advised of all potential risks, consequences, and benefits of telemedicine. You have had the opportunity to ask questions about the information presented on this form and the telemedicine visit. All of your questions have been answered, and you understand the written information provided above.

I agree to participate in telemedicine appointments.

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

Patient Representative Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to pt\_\_\_\_\_\_\_\_\_\_\_

Patient Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_