

Healthy Minds Psychiatry Services Inc.
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www.healthymindspsychservices.com



About Telehealth

Patient Rights

- a. The law requires the patient to be aware of the doctor's credentials. Dr. Bahl is a Double Board-certified Psychiatry by the American Board of Psychiatry and Neurology in Geriatric and adult Psychiatry. For further information you can refer to our website to check Dr Bahl's accreditations.
- b. Laws protecting the privacy and confidentiality of medical information also apply to tele-psychiatry.
- c. The patient has a right to withhold or withdrawal consent to the use of tele-psychiatry during their treatment at any time.
- d. The patient understands that the provider has the right to withhold or withdraw consent for the use of tele-psychiatry at any time during my treatment. The patient understands that all the rules and regulation which apply to the practice of medicine in the state of Virginia also apply to tele-psychiatry.
- e. The provider will not record (video, audio, or photographs) the session without written consent.
- f. The provider will not allow another individual to listen, view or record my tele-visit without my expressed consent.
- g. The provider will make every effort to secure the privacy of the patient during the tele-visit. The provider will use headphones to prevent other individuals from hearing what the patient/others attending the patient's visit may say. The video screen will not be visible to any persons entering the office. In the event of technical difficulties requiring staff assistance, the patient will be notified that a staff member will be able to see the video screen.

Potential Benefits

Tele-psychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances.

Potential Risks

These risks include but may not be limited to:

- a. Psychiatry conducted online is technical in nature and problems may occur with internet connectivity. Any problems with internet connectivity are outside of the control of the provider and the provider makes no guarantee that services will be available or work as expected. If something occurs to prevent or disrupt any

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scheduled appointment due to technical complications and the session cannot be completed via telehealth, we ask that the patient call the provider to our office phone number to see how we can help.

b. Remote intake and management will require the electronic transmission of documents. This will occur via email and may lead to security concerns.

c. Information transmitted may have poor resolution to allow appropriate medical decision making by the provider.

d. The doctor has less ability to facilitate the safe management of the patient when the patient is not in the physical presence of the provider. The provider may not be able to provide for or arrange emergency care that the patient may require in the event of connection failure, failure of the patient or emergency contact to act as directed by the provider, or if the patient is not at a location known to the provider.

e. Delays/or suspension in medical evaluation and treatment may occur due to deficiencies or failures of the equipment, changes to laws regarding the practice of tele-medicine, changes to insurance regulations or other external forces outside of the provider and practice's control.

f. The nature of telehealth can affect provider/patient interaction causing a lack of access to all the information that might be available in a face-to-face visit which may result in errors of medical judgement. Healthy Minds Psychiatry Services will not be able to monitor height, weight, blood pressure, pulse, or conduct in-depth physical exams. This may result in adverse outcomes.

Patient Responsibilities

- a. The patient agrees to take full responsibility for the security of any communication or treatment information conveyed. The patient is solely responsible for conducting the tele-visit in a secure and private location so that others cannot hear the conversation.
- b. The patient will not record (by video, audio, or photographic means) any tele-psychiatry sessions without written consent from the provider. The patient will inform the provider if any other person can hear or see any part of our session before the session begins. It is recommended that the patient use earphones to minimize what others may hear the provider say... The patient accepts all legal responsibility for misrepresentation of the patient's physical location at the time of the visit. It is recommended that visits only be conducted in secure private locations.
- c. The provider is permitted to utilize my emergency contact to assist me should I need emergent care. I understand that if this emergency contact is not available, or cannot assist, we may have to contact emergency services. This is to assist my transport to emergency psychiatric facilities, should I be deemed a current danger to myself or others.
- d. It is the patient's responsibility to provide and configure any electronic equipment used for tele-psychiatry, and to ensure the proper functioning of all electronic equipment before the session begins.
- e. The patient/guardian/ and or person providing insurance coverage agrees to pay all fees associated with tele-psychiatry services. We will follow the customary insurance procedures and file claims for the appointment, however insurance coverage for tele-visits varies by insurance provider. To make the check in and payment process as streamlined as possible, the patient/guardian/ and or person providing insurance coverage is required to keep a credit card on file for the payment of copays, deductibles, and other charges.

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- f. If you are in a location that prevents the proper completion of the visit, i.e., out of state, in a car, in a location without reliable communication services video or phone, you will be charged a \$200 administrative fee (not covered by insurance) and the visit will be rescheduled.

Steps to avoid connectivity during tele-visits.

- a. Use a computer with a web-camera or a tablet and allow camera and microphone on your device settings.
- b. Close any open applications or windows and restart your device prior to the visit.
- c. Do not be traveling or out of the state of Maryland or Virginia without making prior arrangements with our office.
- d. If using a cellphone, enable do not disturb settings. Do not use the phone to check your calendar, email, texts, calls, or attempt to flip the camera outward facing during the appointment. Doing this will often disable the sound or video functions.
- e. Remain in a stationary, private location, preferably with a stable high-speed (non-mobile) internet connection.
- f. Do not conduct your tele-visit while driving or riding in a car.
- g. Use headphones to maximize your privacy.
- h. If the connection is interrupted, log out of the tele-medicine application and attempt to log on again.

The patient is required to comply with the following:

- a. Seeking out specialty assessment, additional testing, or emergency psychiatric evaluations, if deemed necessary by the provider.
- b. Following the recommended follow up appointment schedule
- c. Obtaining and taking prescribed medications or discontinuation of medications prescribed, if deemed inappropriate for continued use by the provider.
- d. Disclosing their exact location during the tele-visit.

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Patient Consent for the Use of Tele-psychiatry

Patient Full Name: _____ **D.O.B:** _____

Back up patient phone number for contact during the visit should connectivity issues arise:

Address of the Patient during the tele-visits:

Emergency contact name and relationship to patient:

Emergency contact phone number: _____

Email address that the patient consents to use for the transmission of documents and correspondence during treatment. This correspondence will contain sensitive patient information: _____

I the patient and/or guardian, have read and understand the information provided in the preceding pages regarding tele-psychiatry. If desired, I have discussed with my provider or staff via phone all questions I had. All my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-psychiatry in my medical care and authorize the provider to use tele-psychiatry during my diagnosis and treatment. By signing this consent, the patient or guardian understand the negative/positive possible impact of tele-medicine management and accepts full responsibility for the risks associated with psychiatric care via remote means.

Patient Name (Print) _____

Date _____

Guardian Signature (if patient is 18 or under) _____

Name of Guardian _____