PATIENT CONSENT FOR TELEPSYCHIATRY

PATIENT: _____

DOB: _____

LAST 4 SSN: _____

In agreeing with this consent, I hereby agree to engage in telehealth psychiatry/mental health therapy with Meridian Mental Health and TMS Center of Omaha." This may include the practice of health care delivery, diagnosis, consultation, treatment transfer of medical data, and education using interactive audio, video or: data communications that may include communication of my medical/mental information to health care practitioners involved in my care.

I understand that I will need to download a HIPPA protected telehealth application and/or software to use this platform. I will be given applicable instructions by my provider. I may contact them via phone to coordinate alternative methods of treatment.

I understand that I have the following rights and responsibilities with respect to telepsychiatry:

1. I have the right to withhold or withdraw consent at any time without affecting my right for future care with my provider.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting certain types of abuse, expressed threats of violence toward any victim, certain legal proceedings as established by statute, and as part of a contractual agreement with your insurance Provider.

3. Charges for telepsychiatry services will be submitted to your insurance carrier, but there is no guarantee that such services will be covered. My provider's staff has made every effort to verify coverage but the ultimate responsibility to verify my out-of- pocket fees will be mine. I am entitled to all appeal processes with my insurance carrier as Is the usual process. If my insurance denies coverage, I will be charged a "self-pay rate" of $185 for a standard 30-minute appointment that is inclusive of evaluation and medication management.

4. I understand that there may be limitations in the technological experience related to telepsychiatry that may be disrupted or distorted by technical failures and that the transmission of my medical information could be interrupted by unauthorized persons and/or that the electronic storage of my medical information could be accessed by unauthorized persons beyond protection provided by my provider and the telehealth platform. At·no time will my telepsychiatry encounter be taped without my prior approval.

5. I have a right to access my mental health records of telepsychiatry services in accordance with the state laws of Nebraska.

PATIENT NAME/SIGNATURE: _____

NAME OF LEGAL PERSONAL REPRESENTATIVE: _____

SIGNATURE WITNESS ONE: _____

SIGNATURE WITNESS TWO {if necessary}: _____

DATE: _____