Amanda Sun, M.D.
Child, Adolescent and Adult Psychiatry
1122 Kenilworth Drive, Suite 100
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Informed Consent for Telepsychiatry

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________
LOCATION OF PATIENT: ____
PATIENT CONTACT INFORMATION: ______________________________________
PHYSICIAN NAME: Amanda Sun, MD
LOCATION OF PHYSICIAN: 1122 Kenilworth Dr, Ste 100 Towson, MD 21204

Introduction

Telepsychiatry is the delivery of psychiatric services using electronic communications, such as audio and/or visual electronic systems where the psychiatrist and the patient are not in the same physical location. Many of the interactive electronic systems used in telepsychiatry incorporate security protocols that are HIPAA compliant, to protect the confidentiality of patient information, audio, and visual data. However, some electronic systems do not contain security protocols, such as the use of cellular phone, and may increase the risk of a breach in privacy of confidential information. The information obtained from electronic communications may be used for diagnosis, therapy, treatment, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and/or video
- Output data from medical devices and sound and video files

Expected Benefits:

- Increased access to psychiatric care by enabling a patient to remain at a remote site
- Increased patient convenience, as the remote site is chosen by the patient and may include the patient's home
- Increased patient and provider safety and decreased risk to health during the COVID-19 pandemic

Possible Risks:

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

- Information transmitted may not be sufficient (e.g. poor resolution of images or audio) to allow for appropriate medical decision making by Dr. Sun.
- Technical issues such as slow internet speed, poor internet connection, and dropped video and/or audio transmission may interfere or interrupt the delivery of psychiatric care.
- A lack of access to all the information that may be available in a face to face visit but not in a telepsychiatry session may result in challenges to clinical decision-making and increased risk for errors.
- Dr. Sun may not be able to provide medical treatment to me/my child using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

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- Security protocols could fail, causing a breach of privacy of personal medical information.
- Use of a telephone, including cellular phone, without security protocols increase the risk of a breach of privacy.

Alternatives to the use of telepsychiatry:

- Traditional face to face sessions with Dr. Sun or another provider.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and Dr. Sun's privacy practices apply to telepsychiatry.

2. I understand that Dr. Sun utilizes Doxy.me which is advertised to be HIPAA compliant to protect my/my child's private medical information, and will not hold Dr. Sun responsible for any unauthorized access to my/my child's private information due to security breaches in Doxy.me.

3. I understand that if I choose to utilize a different means of electronic communication, such as a cellular phone or e-mail, the risk of unauthorized access and breach of privacy is increased compared to HIPAA compliant electronic means of communication.

4. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my/my child's care at any time, without affecting my right to future care or treatment.

5. I understand that Dr. Sun has the right to withhold or withdraw her consent for the use of telepsychiatry during the course of my care at any time. Dr. Sun reserves the right to terminate telepsychiatry services if she does not feel that it is safe or meets the professional standards of care.

6. I understand that alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time. Dr. Sun has explained the alternatives to my satisfaction.

7. I understand that it is my duty to inform Dr. Sun of electronic and in-person interactions regarding my care that I may have with other healthcare providers.

8. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

9. I will not record any telepsychiatry sessions without written consent from Dr. Sun. I understand that Dr. Sun will not record any of our telepsychiatry sessions without my written consent.

10. I will inform Dr. Sun if any other person can hear or see any part of our session before the session begins. Dr. Sun will inform me if any other person can hear or see any part of our session before the session begins.

11. I understand that some forms of medical monitoring for the use and safety of psychiatric medication include medical devices, such as a Blood Pressure and Heart Rate Monitor or a scale to measure weight. If Dr. Sun recommends the use of these forms of equipment to gather health data to monitor my/my child's safety with use of psychiatric medications, it is my responsibility to obtain these forms of equipment. I understand that non-compliance with this recommendation may result in negative consequences to my/my child's physical or mental health.

12. I understand that I am responsible for configuration of any electronic equipment used on my computer (or other electronic device) 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.

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13. I understand that I/my child must be a resident of the state of Maryland or Washington DC to be eligible for telepsychiatry services from Dr. Sun, as these are the states that Dr. Sun is licensed to practice medicine.

14. If you are attending your visit via Doxy.me, the preferred service by Dr. Sun for telepsychiatry, and she does not answer, I will try again in 2-5 minutes as she may be finishing with the previous patient.

Patient Consent to The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my/my child's medical care. I hereby authorize Dr. Sun to use telepsychiatry in the course of my/my child's diagnosis and treatment.

Signature of Patient or Parent/Guardian: ______________________________ *Date:* __________

If authorized signer, relationship to patient: ____

I have been offered a copy of this consent form (patient's initials) ______