CONSENT FOR OUTPATIENT MENTAL HEALTH SERVICES AND TELEPSYCHIATRY

1. CONSENT TO TREAT

I, _____, am presenting myself, or am being presented by, _____, my authorized representative (indicate relationship): _____, for evaluation and/or treatment of a mental health condition on an outpatient basis. I hereby consent to and authorize Fern River Psychiatry, LLC, its health care practitioners and personnel, to perform examinations and/or diagnostic tests, procedures and treatments that in their judgment may promote my mental health. I understand that I have the right to refuse any suggested examinations, tests or treatment.

2. DESCRIPTION, PURPOSE AND BENEFITS

This outpatient mental health treatment is indicated for evaluation and treatment of my mental health condition and/or substance abuse. I understand that the outpatient treatment proposed by the clinician(s) responsible for this care may consist of counseling, medications and other treatments. I further understand that the anticipated benefit of this treatment is to stabilize and/or improve my mental health.

I have been informed that videoconferencing equipment will be used to provide a physician encounter via real-time interactive services. I also have been informed that the encounter will be somewhat different from an in-person patient encounter due to the fact that I will not be in the same room as my telehealth consulting physician. Telepsychiatry allows for more convenient and accessible psychiatric services. Fern River Psychiatry, LLC uses a HIPAA compliant telepsychiatry platform (Zoom) and a secure internet connection.

I understand that I will be informed of the presence of any non-medical personnel in the encounter area and will have the right to request the following:

- omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain in the encounter area;
- ask the non-medical personnel to leave the encounter area; and/or
- terminate the telehealth encounter at any time.

I further understand that either my healthcare provider or I can discontinue the telehealth encounter at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case I will be referred to another health care provider for an in-person evaluation.

3. LIMITATIONS AND RISKS ASSOCIATED WITH OUTPATIENT TREATMENT AND TELEPSYCHIATRY

I understand that there are risks associated with mental health treatment generally, and that there are particular limitations associated with telepsychiatry.

I understand that the usual and most frequent risks involved in mental health treatment include:

- stimulation of unexpected and unpleasant memories of past experiences;

50 Market Street, Ste 1A, #320, S. Portland, ME 04106
Phone: 207-956-0050 Fax: 833-606-1216
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- experience of intense or uncomfortable feelings or impulses that seem difficult to control;
- being challenged or confronted on a particular issue;
- unanticipated changes in my interpersonal relationships with others and how I feel about them; and
- lack of improvement in my condition.

It has been explained to me that there are some limitations and risks inherent in telepsychiatry, as compared to in-person treatment. These include:

- a provider's inability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio;
- interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the encounter;
- unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information;
- patient utilization of a third-party connection to participate in the telepsychiatry encounter at home, which may become insecure, resulting in a breach of my protected health information;
- the presence of third parties in my home who may overhear the telepsychiatry encounter, which may result in a breach of my protected health information; and
- the inadvertent transmission of images of third parties present in my home or of furnishings and personal possessions.

I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth encounter. For these reasons, my particular medical needs may require an in-person encounter with a clinician. The physician performing the telehealth encounter or designee will inform me whether a telehealth encounter is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality.

I have been informed that certain medications (schedule II medications) such as narcotics, stimulants, and benzodiazepines may not be prescribed during a telehealth encounter in the setting of the Ryan Haight Act of 2008 which was created to regulate online internet prescriptions, is enforced by the DEA (Drug Enforcement Agency), and also imposes rules around the prescription of controlled substances through telepsychiatry. It requires an in-person evaluation before a physician can prescribe a controlled substance via telehealth. Due to the COVID Public Health Emergency (PHE) the Ryan Haight Act has been temporarily suspended which allows for prescribing of controlled substances without first having an in-person evaluation. It is anticipated that the Ryan Haight Act will go back into effect once the COVID PHE ends.

If medication is prescribed to improve my mental health, I understand that the side effects of such medication will be discussed with me. I understand that mental health treatment remains an inexact science and no guarantees can be made regarding outcomes.

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4. DURATION OF TREATMENT

The length of treatment for mental health conditions varies among individuals. The clinician(s) involved in this care periodically shall review the anticipated duration of these services with me as part of my individual treatment plan which is part of my confidential medical record. I understand that I will be offered a copy of my discharge plan to facilitate my post-discharge care coordination.

5. ALTERNATIVE COURSES OF TREATMENT

The clinician responsible for this care has explained to me that outpatient treatment is the only recommended form of treatment at this time and that hospitalization may be recommended if my condition does not improve. I understand that the alternative to a telehealth encounter is a visit to another health care provider for an in-person evaluation, diagnosis and treatment which may not occur as quickly as a telehealth encounter can be performed. I have been informed that I may seek other forms of treatment at any time, if I so choose.

6. FURTHER INFORMATION REGARDING TREATMENT

From time to time, Fern River Psychiatry, LLC may communicate with you about matters relating to treatment, alternative therapies, health care providers, settings of care, care management and care coordination.

7. DISCLOSURE OF SUBSTANCE ABUSE TREATMENT RECORDS

If I receive treatment by a federally-assisted alcohol or drug abuse diagnosis or treatment program, then I understand that the program, clinic or practice will, when necessary, obtain my specific consent on a separate authorization form to disclose related information to Fern River Psychiatry, LLC.

I understand that Fern River Psychiatry, LLC will not re-disclose records received from a federally-assisted alcohol or drug abuse diagnosis or treatment program, without my separate written consent.

I understand that other information relating to the diagnosis and treatment of alcohol or drug misuse (that is, information other than the records of federally-assisted alcohol or drug abuse treatment programs) will be available to authorized users, as deemed necessary, within the Fern River Psychiatry, LLC medical record, including the problem list, medication list, diagnosis and allergy fields; among Fern River Psychiatry's professional staff for the purposes of diagnosis and treatment; to complete the responsibilities of the health care professionals involved in my diagnosis and treatment; and included in documents shared with other providers for transitions of care.

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8. MY RIGHTS AND RESPONSIBILITIES

- I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that all the Maine state rules and regulations which apply to psychiatry also apply to telepsychiatry.
- I understand that I must be physically within Maine to be eligible for telepsychiatry services. I will inform my psychiatrist as soon as my session begins of my physical location.
- I will ensure that the proper configuration and functioning of all my electronic equipment prior to my session. I understand the computer, tablet, or mobile device I use must have a working camera and audio input so that my psychiatrist can see and hear me in real time.
- I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session.
- I will not record any telepsychiatry sessions and I understand that my psychiatrist will not record any of our telepsychiatry sessions.
- If I lose connection during a session, I will immediately attempt to log back into the telehealth appointment or contact my psychiatrist via phone, portal message, or email.
- If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or if disconnected, will call to schedule a new appointment.
- I understand that if I am billing my insurance company for telepsychiatry services, it is my responsibility to understand the specifics of how my insurance covers telepsychiatry.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to outpatient mental health / telehealth services, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in the outpatient mental health and telehealth services described here and for purposes of examination, encounter, diagnosis and treatment.

This consent for treatment is valid for a period of one (1) year, from the date of signature.

_____ _____

Signature of Patient or Authorized Representative | Date / Time

_____ _____

Printed Name of Patient or Authorized Representative | Relationship of Authorized Representative

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