**Consent to Participate in Telemedicine Consultation**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that Dr. Rickenbacker, psychiatry, hereafter referred to as ‘my healthcare provider’ or ‘specialist’ has provided me an option to participate in a telemedicine consultation. I understand that the laws that protect privacy and confidentiality of healthcare information apply to telemedicine.

2. My healthcare provider has explained to me how the video conferencing technology will be used. Such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may result in referral to a consulting health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I may revoke my right at any time by contacting Dr. Rickenbacker at 512-690-2075.

4. I understand I am responsible for my selection of telemedicine location and will make every effort to ensure the information I disclose will not be overheard by others. If I believe I cannot protect my privacy due to presence of other individuals at or around my selected location, I will request to terminate the consultation at any time. I will be responsible for a cancellation fee if this occurs.

5. I understand that billing will occur from Dr. Rickenbacker in the same manner as occurs when the appointment is conducted in her office. I understand my healthcare information may be shared with other individuals for scheduling and billing purposes, and my insurance carrier will have access to my medical records for quality review/audit.

* 1. I understand I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
  2. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
  3. I am responsible for any no-show or cancellations in accordance with office policies.

7. I will use a login to a virtual waiting room at the time of my scheduled appointment. That link is presently: <https://DrRickenbacker.doxy.me> The office will notify me if this changes.

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By signing this form, I certify:

* That I have read or had this Telemedicine Consultation Consent form read and/or had this form explained to me. I understand this document will become a part of my medical record.
* That I fully understand its contents including the risks and benefits of the procedure.
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction, and I consent to proceed.
* I am located in the state of Texas and will be in Texas during my telemedicine visit(s).

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Patient Signature Date Time