Tele-Psychiatry Patient Consent/Refusal Form
Dr. Richard R. Hill MD PhD

Patient Name:_____
Date of Birth:_____

I understand and agree that:

- doxy.me will be used as the tele-psychiatry platform, and that doxy.me meets HIPAA security standards.
- I must be in the state of Ohio-the state in which Dr. Hill holds a medical license, in order for the visit to proceed and that the laws of Ohio will apply to my receipt of tele-psychiatry services.
- I must be in my home or in a secure space (i.e.: not traveling in my car or in a space with other people).
- the potential benefits of tele-psychiatry (which are not guaranteed or ensured) include: access to care if I am unable to travel to Dr. Hill's office and during the Covid-19 pandemic, reduced exposure to patients, medical staff and other individuals in the office-thus reducing my risk of contracting the coronavirus.
- potential risks of tele-psychiatry include: limitations imposed by the lack of an in person visit where physical symptoms may be better appreciated, delays in evaluation and treatment due to technical difficulties or interruptions and distortion of the video image resulting from electronic transmission issues.
- While reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the tele-psychiatry visit, risks include unauthorized access to information or loss of information due to technical failures.
- I will not hold Dr. Hill responsible for lost information do to technological failures.
- I may discuss these risks and benefits with Dr. Hill and will be given an opportunity to ask questions about tele-psychiatry services.
- I understand that the level of care provided by Dr. Hill is to be the same level of care provided through an in person medical visit. Further, if Dr. Hill believes I would be better served by a face-to-face encounter this will be recommended for me.
- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room. The number for my local police dept is_____
- I understand that insurance may not cover tele-psychiatry visits and that I am responsible for payment in full.

By signing this informed consent, I am affirming that I have reviewed, understand and accept the risks and benefits of tele-psychiatry as described below and wish to receive such services.

Signature_____ Date_____