Susan S. Eby, APRN
130 Mabry Hood Rd NW, Suite 103
Knoxville, TN 37922
Voice: (865) 314-7002
Fax: (865) 622-7090
www.psychiatristknoxville.com
Skype: susan.eby.aprn

Patient Information and Consent Form for Telepsychiatry Visit Introduction
Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the provider and the patient are not in the same physical location.
The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Potential benefits
Anyone with a computer and a webcam can video conference using Skype (www.skype.com), which is free software. It provides convenience for patients as well as an increased accessibility to psychiatric care.

Potential Risks
As with any medical procedure, there may be 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 video) to allow for appropriate medical decision making by Ms. Eby.
- Ms. Eby may not be able to provide medical treatment to me using interactive electronic equiptment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

Alternatives to the use of telepsychiatry

- Traditional face-to-face session in Ms. Eby's office.
- Evisit

My Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

• I understand that the Skype technology used by Ms. Eby is encrypted to prevent the unauthorized access to my private medical information.

• I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

• I understand that Ms. Eby has the right to withhold or withdraw her consent for the use of telepsychiatry during the course of my care at any time.

• I understand that the all rules and regulations which apply to the practice of medicine in the state of Tennessee also apply to telepsychiatry.

My Responsibilities

• I will not record any telepsychiatry sessions without written consent from Ms. Eby. I understand that Ms. Eby will not record any of our telepsychiatry sessions without my written consent.

• I will inform Ms. Eby if any other person can hear or see any part of our session before the session begins. Ms. Eby will inform me if any other person can hear or see any part of our session before the session begins.

• I understand that I, not Ms. Eby, am responsible for the configuration of any electronic equipment used on my computer 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.

• I understand that I must be a resident of the state of Tennessee to be eligible for telepsychiatry services from Ms. Eby.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Ms. Eby and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Susan S. Eby, APRN, to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for Patient):

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Date:_______________________