Baywell
Psychiatry Group

582 Market Street, Suite 812
San Francisco, CA 94104
Tel 415-922-9122
Fax 415-920-9925
www.baywellpsych.com

Baywell Telehealth Consent Form

Patient Name:________________________________ Date of Birth: _____________________

I understand that my healthcare provider has agreed to engage in a telehealth consultation.

General Information

1. My healthcare provider has explained to me how video conferencing technology will-affect our consultation. I understand that it will not be the same as a direct patient/healthcare provider visit because I will not be in the same room as my healthcare provider.

2. I understand there are potential risks to using this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consultation/visit if it is felt that the video conferencing connections are not adequate for the situation.

3. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and practical alternatives have been discussed with me in a language in which I understand.

Privacy

4. I understand that non-medical personnel other than my healthcare provider may be present during the consultation in order to operate the video equipment. These individuals will maintain the confidentiality of any of healthcare information that they have obtained. I further understand that I will be informed if their presence is required during the consultation. I have the right to request that non-medical personnel leave the telemedicine examination room and I may terminate the consultation at any time.

5. I have had alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that parts of the exam involving physical tests may be conducted by my primary care doctor.

Emergency Situations

6. I understand it is my responsibility to call 911 or go to my nearest emergency room in the event of medical or psychiatric emergency.

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Billing Responsibilities

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

8. I understand that Baywell Psychiatry Group will be billing for all telehealth services. I may be responsible for the full private pay rate if my insurance policy does not cover telehealth visits.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me
• That I fully understand its contents including the risks and benefits of the procedure(s)
• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

____________________________________ ________________
Patient's/Parent/Guardian signature Date