Kim Gaitskill MD
Board Certified
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Consent for Treatment by Telemedicine

Client Name: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation. The type of service to be provided is psychiatric assessment and treatment. The software used for the video sessions in HIPPA compliant.
2. I understand that this service is not the same as a direct patient provider visit because I will not be in the same room as the provider performing the service.
3. I understand that although the sessions are conducted by video, they are NOT recorded or stored in any way.
4. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
5. I understand there are potential risks to this technology, including interruptions, due to technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I can terminate the consultation at any time.
6. I understand that the telemedicine service is not an appropriate modality to use during an emergency. I will follow recommendations from my therapist in event of an emergency.
7. I understand that my healthcare information may be shared with other individuals for billing and insurance purposes just as it may be shared when attending face-to-face sessions. I understand that if my insurance does not cover the telemedicine services, I am responsible for payment.
8. It is the responsibility of the telemedicine provider to conclude the service upon termination of the videoconference connection.
9. I agree that there are no guarantees or assurances made about the results of this videoconferencing service.
10. I acknowledge that the telemedicine programs late-cancellation/no-show policy is the same as face to face sessions with Kim Gaitskill, MD.
11. I agree to participate in telemedicine (videoconferencing) services with Kim Gaitskill, MD.

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 signature Date