CONSENT TO PARTICIPATE IN TELEPSYCHIATRY CONSULTATION

1. **PURPOSE**. The purpose of this form is to obtain your consent for a telepsychiatry consultation with Esther Samadi, M.D.

2. **NATURE OF TELEPSYCHIATRY CONSUTATION**: telepsychiatry involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider, and/or review your medical information for the purpose of diagnosis, therapy, follow-up, and/or education. During our telepsychiatry consultation, details of your medical history and personal health information may be discussed with other health professionals through the use interactive video, audio, and telecommunications technology.

3. **RISKS, BENEFITS AND ALTERNATIVES**. The benefits of telepsychiatry include having access to services from Esther Samadi, M.D. without having to travel. A potential risk of telepsychiatry is that due to certain clinical presentations or technical problems, a face-to-face consultation may still be necessary after the telepsychiatry appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telepsychiatry consultation is a face-to-face visit with Esther Samadi, M.D**.**

4. **MEDICAL INFORMATION AND RECORDS**. All laws concerning patient access to medical records and copies of medical records apply to telepsychiatry. Dissemination of any patient identifiable images or information from the telepsychiatry consultation to researchers or other entities shall not occur without your consent.

5. **CONFIDENTIALITY**. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telepsychiatry consultation. Doxy.me and Doximity are HIPAA compliant telepsychiatry platforms that operate in accordance with HIPAA regulations and privacy/security rules. Doxy.me does not permanently store protected health information**.**

6. **RIGHTS**. You may withhold or withdraw your consent to a telepsychiatry consultation at any time before and/or during the consult without affecting your right to future treatment with Esther Samadi, M.D.

7. **FEES**. Esther Samadi, M.D. is not in-network with any insurance company. Therefore the patient and/or identified responsible parties are responsible for full payment at the time of each service. If you have out-of-network benefits, Esther Samadi, M.D., will provide you a superbill after each appointment to submit to insurance for reimbursement.

By signing below, I acknowledge that Esther Samadi, M.D. has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read this document in full and beginning on this date, I agree to receive telepsychiatry consultations with Esther Samadi, M.D.

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Signature of Patient or Patient Representative Date of Signing

_____ _____

Patient Name Patient Date of Birth