



TELEMEDICINE CONSENT

I understand that I voluntarily requested to engage in a telemedicine consultation for psychiatric services.

Dr. Baez has explained to me how the video conferencing technology will be used during my session. I am aware I will not be in the same room as my health care provider as I will be seen remotely via televideo.

2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that Dr. Baez or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

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

4. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of Dr. Baez.

5. In an emergent consultation, I understand that the responsibility of Dr. Baez is to advise my emergency contact and if necessary Dr. Baez will conclude the video conference connection and referred to a local hospital or contact 911.

6. I understand the fees for the sessions are prepaid and not reimbursable except as stipulates in the missed session policy. This policy is available on the web at www.sbaezmd.com

7. 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 any practical alternatives have been discussed with me in a language in which I understand.

8. I understand that if Dr. Baez does not feel that she will be able to provide me adequate care she will refer me to other resources or providers. I understand that labs or other procedures may be necessary before prescribing takes place. **I understand that controlled medications will not be prescribed by Dr. Baez and alternatives will be discussed at the time of your session.**

Date: _____

Patient Name: _____

Signature: _____