Psychiatric Services Consent for Electronic Communication

I give permission for Dr. Amanda Williams and/or her staff to leave messages regarding appointments and prescriptions refills on voicemail and/or send appointment reminders and prescription refill updates via email.

With your consent and if not clinically contraindicated, Dr. Amanda Williams may provide services electronically, including using telephone and video conferencing (i.e. doxy.me). Routine scheduling occurs online via FullSlate or by telephone at 404-847-9560.

Email may be used in the delivery of some services to augment or follow up on sessions. In these cases, Dr. Amanda Williams may provide updates, invoices, account statement summaries, memoranda, education resources and/or exchange information.

Telepsychiatry Services

Telepsychiatry as an alternative to in-person appointments, involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office. There may also be a disruption of service (e.g. the phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. You agree to hold Dr. Amanda Williams harmless for information lost due to technical failures.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Video-conferencing will require a computer with a webcam or a smartphone with working camera. It is important to be in a quiet, private space that is free of distractions during the session. It is important to use a secure internet connection rather than public/free Wi-Fi. Dr. Amanda Williams will utilize only HIPAA compliant encrypted telemedicine technologies. You agree to advise Dr. Amanda Williams if someone comes into the room in which you are communicating with Dr. Amanda Williams or if someone is within earshot. Please keep in mind that other individuals (living in your home) may be able to access information, sensitive or otherwise, communicated electronically or by telephone.

In the event of technical problems, you agree to the backup plan of a phone number where you can be reached to restart the session or to reschedule it. Please make sure that you have your phone with you and that I have the phone number. If we get disconnected from video conferencing, please end and then restart the session. If we are unable to reconnect within a few minutes, I will call you at your designated phone number.

Any communications provided by Dr. Amanda Williams or by her staff are intended for you and not for others unless agreed to otherwise. By signing this Informed Consent, you are confirming that you have taken reasonable steps to secure your own electronic devices (mobile phone, tablet, iPad, desktop, laptop, or any electronic devices you have in your household or designated private area). This includes having confidential password and adequate firewalls. Dr. Amanda Williams does not consent to any recording of electronic sessions.

As your psychiatrist, I may determine that due to certain circumstances, telepsychiatry is no longer appropriate and that in-person sessions are required. If an in-person appointment with Dr. Amanda Williams is not possible, you may be referred elsewhere for in-person assessment.

Although there are temporary and limited exceptions due to the Covid 19 pandemic, if you move out of state, Dr. Amanda Williams may not treat you due to State licensing laws.

Emergency Procedures Specific to Telepsychiatry Services

- You understand that if you are having active suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and telepsychiatry services are not appropriate.

- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. In the even of an emergency, either you or I will verify that your ECP is willing and able to go to your location. Additionally, if you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances states above. Please list your ECP here:

Name:_____ Phone:_____

- You agree to inform me of the exact address where you are located at the beginning of every Telepsychiatry session if this is different than the home address you supplied on your registration forms.
- You agree to inform me of the nearest psychiatric hospital or Emergency Room to your primary locations that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a telepsychiatry session). Please list this hospital and contact number here:

Hospital:_____ Phone:_____

I have read and understand the above policies.

_____
Patient's Signature

_____
Printed Name

_____
Date

_____
If applicable, Guardian Signature