

Patient Consent for Telebehavioral Healthcare Services

Alaska Psychiatric Institute
Telebehavioral Healthcare Services
(Provider Please Fax Completed Form to 269-7129)

- 1) I understand that my local healthcare or behavioral provider has asked an Anchorage specialist to assist with my behavioral healthcare services. The Anchorage specialist will see me through a live, private video. My local providers have asked for assistance that is not available in my community. I understand that my local providers and I will still make the decisions about what treatment I may or may not receive.
- 2) I understand that because this is a telebehavioral health appointment, it may sometimes be necessary for someone who works with the specialists in Anchorage to monitor the video to make sure the equipment is working. All staff will keep my information confidential.
- 3) I understand that my local provider will schedule appointments with the Anchorage provider. The Anchorage provider will only be available during the scheduled appointment times. I will need to contact my local provider with urgent concerns. I understand that I will need to contact my local healthcare emergency provider for emergencies.
- 4) I understand that this service is completely voluntary and that I can choose not to answer questions at any time. I may stop participating at any time.
- 5) I understand that the Anchorage specialist can not physically examine me, nor physically intervene if needed for my health, and that only my local health care providers can provide such services to me.
- 6) I understand that none of the services provided will be recorded or photographed unless I am asked and agree.
- 7) I understand that my local health care medical records will contain a copy of this consultation, and that my local health care providers will work with me on the treatment plan for my mental health.
- 8) I understand that I have a choice to allow anyone else to be present here or at the Anchorage site during my appointments. However, I understand that the Anchorage specialist may need the local provider to sit in the room to assist with my services.
- 9) I understand that I may be contacted after my appointment so API can ask me about the quality of the services I received. I may be asked to give my opinion of the services I received and asked for suggestions about how it can be done better in the future.
- 10) I agree to the telemedicine service described above. I agree that all of my questions have been answered about the telebehavioral healthcare service.

Signature: _____ Date: _____
(Patient/Legal Guardian)

Patient name (please print): _____

Witness signature: _____