Xenia Protopopescu, MD PhD
One Park Ave, 8th Floor; New York, NY 10016; 646-363-6590

Telepsychiatry Informed Consent

I _____ hereby consent to engaging in telemedicine with Dr. Xenia Protopopescu as part of my psychiatric treatment. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. The Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical or geographic limitations. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information to other health care practitioners.

Technology: I understand that I may need to download an application and/or software to use the platform (currently: https://doxy.md/drprotopopescu). I also need to have a broadband Internet connection or a smart phone device with a good cellular connection.

Financial Obligations: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the cancellation policy of full session fee charged for missed appointments with less than 48 hours notice. In the event of being very late for appointments, I understand that I may also be charged for the cost of time associated with lateness which is not billable to insurance (the shorter session which is billable to insurance for out-of-network reimbursement may have a lower associated fee than the intended session time was reserved for and I am personally responsible for the cost difference).

Scheduling: I understand that scheduling is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: Telemedicine sessions are NOT recorded without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

Please initial after reading this page: _____

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my psychiatrist, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.
4. I understand that Dr. Protopopescu may not provide telemedicine services to me if I am outside of the states where she is licensed (New York, New Jersey, Connecticut, and Pennsylvania) and I understand that I may access telemedicine services with Dr. Protopopescu from within the States of New York, New Jersey, Connecticut, and Pennsylvania only.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with state law.

I have read and understand the information provided above. I have discussed it with Dr. Protopopescu, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using a telemedicine platform.

_____

Client Name and Signature and Date

_____

Client Guardian's Name and Signature and Date

_____

Provider's Name and Signature and Date