COVID-19 Telehealth Information and Procedures

We care about the health and well-being of our patients and providers. We want to assure that your mental health treatment is not interrupted. Continuing your treatment using video-calls is a a good option. Some providers may provide telephone check-ins. Most insurance providers cover video-call appointments, but fewer cover telephone contact. We encourage you to work with your insurer to assure you receive your benefits.

HIPAA compliance is not required during the COVID-19 emergency. Even so, all our providers use encrypted video-calls that meet the most critical criteria for assuring your privacy. We prefer to use Zoom, but some providers may connect thru other secure platforms (FaceTime, Skype, WhatsApp, Doxy).

Once you have a confirmed telehealth appointment, we will need your e-mail address to facilitate smooth connections. Staff may call from off-site numbers, so you may miss our calls if you block or do not answer unknown numbers.

Current patients seen in the past 12 months:
Call the front desk when you are ready to convert your upcoming appointments to telehealth at 608-238-9354.

When you have a telehealth appointment scheduled, read the Consent for Telehealth Service at the end of this page. Fill in your name at the top and sign at the bottom, either as a fillable PDF or by printing it and handwriting. Please note if you signed digitally. Send it back by:

1) mail to 2727 Marshall Court, Madison, WI 53705 or
2) fax to 608-238-7675 or
3) e-mail the PDF, a photo, or scanned copy to hrpssc@psychsvcs.com

New patients OR **Patients who have not been seen in the past 12 months:**
We must have the following forms completed and returned to us at least 2 days before your scheduled appointment so we can contact your insurance company to assure coverage. Use the fillable PDF function, or print and handwrite your responses. If you are signing digitally, please note that.

1) Read the Consent for Telehealth Service at the end of this page. Fill in your name at the top and sign at the bottom.

2) Go back to Forms and read the Notice of Patient Rights. (You don't have to print this one.)

3) Go back to Forms to complete the Registration Form. Be sure to **sign the second page** that acknowledges you read about your privacy rights.

4) Go back to Forms to complete the Informed Consent. Sign all **three signature spots**.

5) Send signed forms (Registration, Informed Consent, Consent for Telemedicine Service) by:

1) mail to 2727 Marshall Court, Madison, WI 53705 or
2) fax to 608-238-7675 or
3) e-mail the PDF, a photo, or scanned copy to hrpssc@psychsvcs.com

If you are having technical difficulties, please call us at 608-238-9354 and we'll do our best to assist you.

Psychiatric Services, S.C.
Consent for Telehealth Services

Name:_____Date of Birth:_____

My Provider(s)_____

1. I understand that I am giving consent to participate in mental health treatment through video-conferencing and/or audio-conferencing (telehealth) with the provider(s) stated above, or other providers at Psychiatric Services as needed.

2. I understand that a telehealth session will not be identical to an in-person visit because I will not be in the same room as my provider(s). Limitations of this service may include stronger feelings of distress or lessened feelings of satisfaction. I understand that I may choose to terminate the telehealth session at any point and will be billed only for the time spent.

3. I understand that potential risks include interruptions due to technical difficulties, and that the session may be discontinued by my provider if the video or audio connections are inadequate for treatment.

4. If an urgent or emergency situation arises during the telehealth session, I agree to follow the directions of my provider(s) for additional treatment that may include seeking in-person treatment at a clinic, hospital or emergency room.

5. I understand that fees for treatment are billed at the usual and customary rate for services, as indicated by my signature on the Informed Consent form. Please process my bill as indicated by my mark below:

____I personally accept responsibility for payment of telehealth services, so request that my insurance carrier(s) not be billed.

____Payment for telehealth services will include reimbursement from my insurance carrier. I accept responsibility for co-pays, deductibles and policy limits of my insurance as indicated on the Informed Consent form.

By signing this form, I certify that I have read this form and understand its contents including the risks and benefits of the procedure(s), and my rights and responsibilities as described above.

_____ _____
Signature of client (age 14 or older) Date

_____ _____
Signature of client's parent/guardian (for minors only) Date