Catherine McCarthy, MD, PLLC
6723 Whittier Avenue, Suite 403
McLean, VA 22101
(703) 288-3535

Telehealth and Videoconferencing Consent Form

1. I/my child _____ am/is a patient of Dr. Catherine McCarthy.
2. Dr. McCarthy, having completed an intake of me/my child and having established a therapeutic, doctor-patient relationship, is offering to conduct sessions via telehealth/telepsychiatry. This is the delivery system of services via videoconferencing, where the patient and the doctor are not in the same location. This may be necessary under particular circumstances such as illness, hazardous weather, or a wide-spread medical situation where in-person contact may pose a risk.
3. The videoconferencing system Dr. McCarthy currently uses is doxy.me/drcmc. Dr. McCarthy may eventually use other platforms as she seeks the most user-friendly and reliable system (Zoom, for example, is popular, but has been intermittently overloaded.) The systems under consideration meet HIPAA standards of encryption and privacy. For circumstances outside of Dr. McCarthy's control, such privacy may not be absolute. However, extraordinary circumstances (such as a world pandemic) may, at times, require extraordinary measures (like "Facetime," which is not HIPAA Compliant/secure). Together, we will do our best to figure out how to manage communication with common sense during this very stressful global situation. It appears the medical boards are waiving many HIPAA telemedicine regulations and that Facetime may be reasonable given the emergency.
4. I understand the benefits of videoconferencing, such as more convenient access to care and reduction of such barriers as traffic, illness exposure, or travel time. Dr. McCarthy and I have discussed the benefits of this mode of care for my/my child's particular needs.
5. I understand that Dr. McCarthy is licensed to practice medicine in Virginia and may only provide this service when a patient resides in Virginia. Hopefully, this requirement is going to be lifted soon at the discretion of the federal government or other states. Dr. McCarthy will need to receive official notice that such federal/state permission has been given.
6. I understand that the requirements, shortcomings, and hazards of videoconferencing may include:

a. Encryption may not be foolproof.

b. There can be a disruption of signal or transmission at any time. If that occurs, the session can continue by telephone. If this happens too frequently for videoconferencing to be practical, Dr. McCarthy will discuss alternatives.

c. Non-verbal cues of communication may be lost.

d. Dr. McCarthy will not be able to take my/my child's height, weight, pulse, or blood pressure. I will need to provide these measurements as recorded by my/my child's primary care doctor. I understand that Dr. McCarthy may require these, as well as any labs, to continue medication.

e. Dr. McCarthy can still call in or electronically prescribe certain medications to my pharmacy, as long as I/my child keep/keeps the regularly scheduled telepsychiatry appointments as per Dr. McCarthy's longstanding policy.

f. I/my child will need to choose a private location in my home, where I/my child will reduce the chance of being overheard. Dr. McCarthy cannot guarantee I/my child will have the same privacy as in her office. I/my child may further reduce inadvertent disclosures of information by wearing headphones.

g. I am responsible for checking with my insurance company to determine coverage for telepsychiatry. Dr. McCarthy will apply the applicable suffixes to the services on my bill. Dr. McCarthy will discuss this issue with patients and parents directly.

h. I am responsible for payment as soon as possible after service is rendered. If I do not meet this requirement, advance payment of services may be deemed necessary. This policy is unchanged from the previous office policy, in which payment is due at the time of service.

i. If Dr. McCarthy determines that I/my child pose(s) an imminent danger to myself or others, Dr. McCarthy will contact the necessary authorities. I will provide Dr. McCarthy with the name and phone number of an emergency contact person, and I will give Dr. McCarthy written permission to contact that individual if she reasonably believes I/my child am/is in danger or crisis and may not be able to help my/him/herself.

Emergency Contact

Name _____

Phone _____

Alternate Phone _____

j. I also understand that I/my child may need to seek in-person mental health services with Dr. McCarthy, a local crisis center, or emergency room should videoconferencing be insufficient to address my needs.

k. If Dr. McCarthy or I believe that videoconferencing does not serve my/my child's needs, we will review alternatives, including in-person sessions, transfer to another clinician, or transfer to a higher level of care.

7. I understand Dr. McCarthy will resume in-person meetings when conditions necessitating videoconferencing have abated.

8. Between sessions, if I/my child require(s) assistance, I may contact Dr. McCarthy via office phone at (703) 288-3535.

By signing this agreement, I declare I have read this document and have had questions answered to my satisfaction. I give my permission that my emergency contact individual may be alerted if Dr. McCarthy reasonably believes I/my child pose(s) a danger to my/him/herself or others and am/is unable to help my/him/herself.

_____

Patient Printed Name

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Dr. Catherine McCarthy Date