Silver Psychiatric Services, PC
Randie Schacter, DO
212 W. Matthews Street Suite 106
Matthews, NC 28105
Tel 704-847-0424 Fax 704-847-0454
office@silverpsychiatric.com

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Dr. Schacter has offered to communicate using the following means of electronic communication ("the Services") [check all that apply]:

- ☐ Email
- ☐ Website/Portal
- ☐ Appointment reminders by texts **(NOT FOR ANY OTHER PURPOSE)**
- ☐ Videoconferencing (including Skype®, FaceTime®)
- ☐ Other (specify): _____

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with Dr. Schacter and her staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that Dr. Schacter may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with Dr. Schacter or her staff using the Services may not be encrypted. Despite this, I agree to communicate with Dr. Schacter and her staff using these Services with a full understanding of the risk. I acknowledge that either I or Dr. Schacter may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

I also acknowledge that <u>outside of our appointment times</u> (where information can be shared live over a secure portal), <u>all electronic communication is limited to administrative, non-clinical, non-emergent or non-urgent issues</u> and that it is my responsibility to follow up with Dr. Schacter's office by phone or in session for clinical issues regarding symptoms and medications.

I further understand that I may request a copy of this signed authorization.

Patient name: _____

Patient address: _____

Patient home phone: _____ Patient mobile phone: _____

Patient email (if applicable): _____

Signature of Patient/Authorized Person: _____Date: _____

Name of Authorized Person: _____ Relationship: _____

APPENDIX

Risks of using electronic communication

The Physician/Office will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician/Office cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician/Office or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While the Physician/Office will attempt to review and respond in a timely fashion to your electronic communication, **the Physician/Office cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters!**
- If your electronic communication requires or invites a response from the Physician/Office and you have not received a response within a reasonable time period, **it is your responsibility** to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician/Office might use one or more of the Services to communicate with those involved in your care. The Physician/Office will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

- You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

O Sexually transmitted disease
O AIDS/HIV
O Mental health
O Developmental disability
O Substance abuse
O Other (specify):

- You agree to inform the Physician/Office of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician/Office in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician/Office is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician/Office of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication and your full name in the body of the message.
- Review all electronic communications to ensure they are clear, and that all relevant information is provided before sending to the Physician/Office.

I further understand that I may request a copy of this signed authorization.

_____ _____

Patient/Patient Representative Signature Date

Should you choose to **REFUSE/REVOKE PERMISSION** to release the above listed information, sign below

_____ _____

Patient/Patient Representative Signature Date

Legal Authority to sign for patient: ___ Parent ___ Guardian ___ Other (specify)

_____

Patient is: ___ Minor ___ Disabled ___ Deceased ___ Incompetent ___ Incapacitated