PLEASE READ

This is an application to establish care via Telemedicine with Mind Matters PsychiatryMD.

Please sign and complete each form below. For clarification, **do not** email us, instead please call the office at 972-221-7900.

Please **fax back completed forms to our secure fax at 972-221-7901**. A credit card signature is required to proceed with telemedicine.

Thank you for your patience and cooperation during this challenging time as we strive to accommodate you, our most important client!

Mind Matters PsychiatryMD Informed Consent for Telemedicine Services

Patient Name: _____ DOB: _____ Patient ID: _____

Location of Patient: _____

Practitioners Name: _____

Circle Location: 2620 Long Prairie RD #100 Flower, Mound, Tx 75022

3140 Legacy Drive #130 Frisco, Tx 75034

1701 River Run Ste 1118 Fort Worth, Tx 76107

Date Consent Discussed: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home or secure location while the practitioner provides non urgent/crisis medication management, individual or family psychotherapy sessions.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any behavioral health evaluation, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

• In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).

• Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

• In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page: _____ 

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Practitioner has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my Practitioner of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (Dr. Oladele Adebogun or any of his delegated providers) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____
Date: _____

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____

Mind Matters PsychiatryMD
2620 Long Prairie RD #100
Flower Mound, TX 75022
972-221-7900 ext 1

Credit Card Authorization Form (To Vault Credit Card)

Sign and complete this form to authorize **Adebogun MD.,PA** to make a debit charge & vault to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for this transaction and to vault your card in our secure safe for future charges **ONLY** at your request.

Please Complete the information below:

I _____ authorize **Adebogun MD .,PA** to charge
(Full name)
account indicated below for _____ on or after _____.
(Amount) (Date)

This payment is for _____ .
(Medical services)

Billing Address_____ Phone #_____

City, State, Zip_____

Email_____

SIGNATURE_____DATE_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only and is valid for this transaction and any other requested transactions. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Mind Matters PsychiatryMD

Credit Card Authorization Form (To Vault Credit Card)

CARDHOLDER INFORMATION

Name:_____

Billing Address: _____

City: _____ State: _____Postal Code:_____

Country: _____ Email:_____

Direct Telephone: ( )_____-_____

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ Discover Card

Number: _____

Expiration Month: _____ Expiration Year: _____

Security Code: _____ (3-digit on back of card)

Cardholder Signature: _____ Date___/____/____

This portion of the form will be shredded immediately once payment is processed.