PRMS®
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# Telepsychiatry Questionnaire

**If you are practicing telepsychiatry, we want to ensure that we have complete and accurate information on file for coverage purposes**. If you are not currently practicing any telepsychiatry, you may disregard this document.

First name: _____ Last Name: _____ Degree: _____

Email: _____ Phone: _____

In which state(s) are your patients located when they are receiving telepsychiatry services?

- Majority (please include the county): _____
- Other states, if any (county not required): _____

❑ Please check to confirm you have reviewed and agree to the following:

1. I comply with the applicable laws and regulations by the state(s) and, if prescribing controlled substances, federal government as well as the relevant agencies. This includes, but is not limited to, prescribing requirements and an in-person examination.
2. Services are considered rendered in the patient's state, not my location.
3. The patient location is confirmed at the start of every session.
4. I am using applicable HIPAA-compliant equipment. If the equipment vendor stores any patient information, I have a Business Associate Agreement from the vendor.
5. Informed consent includes the use of telepsychiatry.
6. Patients can decline treatment via telepsychiatry.
7. I have contingency plans for emergencies and technical failures.

For more information and risk management resources on telepsychiatry and cybersecurity, please visit www.PRMS.com/TelepsychChecklist .

PRMS clients may also log into www.PRMS.com/MyProgram and click PRMS U for additional educational resources.