Pediatric Therapy Links, LLC

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Consent for Teletherapy Services and Treatment

_____ _____ _____

Patient Name (Last, First) DOB Date

Teletherapy includes the use of electronic communications by a health care provider for the diagnosis, treatment, and/ or consultation of Speech Language Therapy and/ or Occupational Therapy services.

Patient's Rights, Responsibilities, and Risks

I understand that I have the following rights, responsibilities, and risks with respect to teletherapy services.

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I understand that the laws that protect the privacy and the confidentiality of medical information also apply to teletherapy, and no protected health information from teletherapy interaction will be disclosed to other parties without prior consent, except as permitted by law. To ensure this, patients and therapists are not permitted to record the therapy sessions or evaluations conducted via teletherapy.
- I understand that while teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all patients will be effective.
- The patient/ parent/ legal guardian is responsible for:
    - Providing the necessary computer, Ipad, or other similar device; as well as, the internet access for the teletherapy sessions.
    - The information security of their personal computer.
    - Arranging a location that is conducive for the child's learning and is free from distractions with appropriate lighting.
    - For minor patients, under the age of 18, a parent or an adult caregiver, must be present for the entire evaluation or therapy session.
- I understand teletherapy involves the use of electronic information.
- I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts to ensure high encryption and secure technology on the part of Pediatric Therapy Links, LLC, that the transmission of patient information could be disrupted or distorted by technical failures, the transmission of patient information might be interrupted by unauthorized persons, and or the electronic storage of patient medical information could be access by unauthorized persons.

Consent for Treatment: I consent to receive diagnostic and treatment via Teletherapy performed by Pediatric Therapy Links, LLC over a secure video conferencing platform for medically necessary Speech Language Therapy and/ or Occupational Therapy. Any copays, deductibles, coinsurances, and/ or self-payments that apply will be the patient's responsibility.

I have read the information provided above and I fully understand its contents including the risks and benefits of teletherapy services. I hereby give my informed consent for the use of Teletherapy and all my questions have been answered prior to signing this document.

_____ _____

Signature of Patient, Parent, or Legal Guardian Print Name

Email: _____ Phone: _____