TELETHERAPY CONSENT FORM

Telepractice (the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation."

The therapist and the child would join a computer based session at the designated therapy time, and would work on the same materials as in the office. We term this “teletherapy.” It is important to know that this service delivery model is supported through the Virginia licensing board and is payable by most insurance carriers per the Telehealth Enhancement Act of 2013- H.R.3306, 113th Congress.

This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions. I _____hereby consent to allow my child _____ to engage in teletherapy with Pediatric Therapy Studio, LLC. I understand that “teletherapy” includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy _____ (Initials)

As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential _____ (Initials)

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Pediatric Therapy Studio, LLC, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons _____ (Initials)

Pediatric Therapy Studio, LLC currently uses Thera - LINK to provide teletherapy services.

I understand that I am responsible for

(1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions,

(2) the information security on my computer, and

(3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task. Teletherapy may be used as the primary means of service delivery only during the COVID-19 pandemic.

I have read, understand and agree to the information provided abov

_____
Name of Client

_____
Name of Parent/Guardian/Caregiver

_____
Signature of Name of Parent/Guardian/Caregiver

_____
Date