Corrective Speech and Language Therapy, Inc.
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INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to consult, treat and educate using interactive audio, video or data communication regarding my treatment. This means that we are able to provide therapy services through digital meetings similar to the popular communication system "FaceTime", but through a secure and HIPAA compliant portal. While we do not specifically use FaceTime for services the method of delivery would be similar in nature. The therapist and patient would join a computer based session at the designated therapy time, and would work on the same materials as in the office. This mode of service delivery, when implemented correctly, has showed to have equal outcomes to face-to-face interventions.

I, _____hereby consent to engage and participate and/or have my child engage and participate in therapy via computer, telephone or internet (hereinafter referred to as Telehealth) with Beyond Therapy. I understand that teletherapy also involves the communication of the patient's medical information, both orally and visually.

Patient: _____ Date: _____

I understand I have the following rights with respect to Telehealth under this agreement:

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. As such, I understand that that the information disclosed by me during the course of therapy is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Beyond Therapy, 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. Beyond Therapy currently uses to Doxy.me to provide teletherapy services but this is subject to change.

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 as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. 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, or may be used in combination with in-person services.

I have read, understand and agree to the information provided above.

_____ _____ _____

Patient Name (Printed) **Patient/Guardian Signature** **Date**