Teletherapy Informed Consent Form

I ____hereby consent to engage in teletherapy/coaching with Crossway Pediatric Therapy. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Crossway Pediatric 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.
4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if Crossway Pediatric Therapy believes I would be better served by another form of therapeutic services (e.g. face-to-face services). Finally, I understand that there are potential risks and benefits associated with any form of Occupational, Physical and Speech Therapy and that despite my efforts and the efforts of my therapist, my condition may not be improve, and in some cases may even get worse

I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

5. I accept that teletherapy does not provide emergency services. During our first session, Crossway Pediatric Therapy and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911.
6. 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.
7. I understand that while email may be used to communicate with Crossway Pediatric Therapy, confidentiality of emails cannot be guaranteed.
8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

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

Client (or Guardian's) Signature __________________________________ Date _______________________

Client Name ____________________________

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