**Informed Consent for Teletherapy**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Public Schools

***[Address]***

## CONSENT FOR TELETHERAPY SERVICES

1. I understand that my speech- language pathologist, occupational therapist, and/or physical therapist wishes me to engage in a teletherapy services.
2. My speech- language pathologist, occupational therapist, and/or physical therapist explained to me how the video conferencing technology that will be used to affect such a service will work during therapy sessions.
3. I understand that a teletherapy service has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the teletherapy consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a **direct conversation OR personal message** with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

**CONSENT TO USE THE TELETHERAPY BY *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* School District**

ZOOM or GOOGLE HANGOUT/ MEET is the teletherapy service we will use to conduct teletherapy video conferencing appointments. By signing this document, I acknowledge:

1. Though my provider and I may be in direct, virtual contact through the Teletherapy Service, neither the Teletherapy service or speech pathologist, occupational therapist, and/or physical therapist provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
2. The Teletherapy Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
3. I do not assume that my provider has access to any or all of the technical information in the Teletherapy Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Teletherapy Service.
4. To maintain confidentiality, I will not share my teletherapy appointment link with anyone unauthorized to attend the appointment.

**By signing this form, I certify:**

* That I have read or had this form read and/or had this form explained to me
* That I fully understand its contents including the risks and benefits of the procedure(s).
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

## Patient/Guardian if patient under 18 Date

**Student: Date of Birth:**