Bartlesville Hope
Pediatric Therapy

TELETHERAPY CONSENT FORM

I understand that teletherapy is a form of speech, feeding, occupational, or physical therapy services provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical health information both orally and/or visually. Teletherapy has the same purpose or intention as treatment sessions that are conducted in person; however, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of Oklahoma.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. 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 confidential.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, 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 there is a risk that services could be disrupted or distorted by unforeseen technical problems.
5. I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be provided additional therapy options to pursue.
6. I understand that results of teletherapy cannot be guaranteed or assured.
7. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions. It is the responsibility of the treatment provider to do the same on their end.
8. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding telehealth. I hereby consent to telehealth on behalf of this patient.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name of Parent/Guardian Patient Name