Central Texas
Speech Pathology Services, Inc.

Consent for Teletherapy

2 pages

Patient Name: _____ Date of Birth: _____

To better serve the needs of the community, healthcare services are now available by interactive video communications and/or by the electronic transmission of information. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals ("Treatment Providers") at different locations to share individual client clinical information for the purpose of improving client care. The information may be used for healthcare delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education, and may include client clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and information. It is important that you understand and agree to the following statements.

Expected Benefits:

1. Improved access to healthcare by enabling a client to remain at a remote site while consulting with Treatment Provider.

2. More efficient healthcare evaluation and management.

3. Obtaining the expertise of a distant specialist.

Possible Risks: Although rare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);

2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;

Necessity of In-Person Evaluation:

A variety of alternative methods of clinical care may be available. A client may request alternative methods of care to telehealth from Treatment Provider. Telehealth-based services and care may not be

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as complete as face-to-face services. There are potential risks and benefits associated with any form of treatment, and that despite client efforts and the efforts of Treatment Provider, a condition may not improve, and in some cases may even get worse. If it becomes clear that the telehealth modality is unable to provide adequate treatment, the Treatment Provider will make recommendations to the client for further care.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of clinical information also apply to telehealth. I understand that the information disclosed by me during the course of my treatment is confidential.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

4. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.

5. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available.

I will ensure confidentiality of my sessions by attending in a private setting.

In case of life-threatening emergency, call 911 immediately.

Please notify your therapist for any concerns you may have regarding your care.

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my speech pathologist. I hereby give my informed consent for the use of telehealth in my clinical care. I hereby authorize Central Texas Speech Pathology Services, Inc. to use telehealth in the course of my treatment.

_____ _____

Signature Date

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