Gulf Breeze ABA

Telehealth Consent Form

1. I authorize Gulf Breeze Behavior Analytic Services and Consultation LLC or Gulf Breeze ABA to allow me/the client/parent/caregiver to participate in telehealth (videoconferencing) service. _____(initial)
2. The type of service to be provided by via telehealth will be observation, parent or caregiver guidance and training.
3. I understand that this service is not the same as a direct therapy ABA provider visit, because I/the client/parent/caregiver will not be in the same room as the Gulf Breeze ABA provider performing the service. _____(initial)
4. My/the client/parent/caregiver's provider has fully explained to me the nature and purpose of the videoconferencing technology, which includes virtual parent or caregiver guidance and training services. I have been informed of the expected risks, benefits and complications (from known and unknown causes), that may arise during the telehealth session. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. _____(initial)
5. I understand that there are potential risks to the use of this technology, including but not limited to, interruptions, unauthorized access by third parties, and technical difficulties. I am aware that Gulf Breeze ABA can discontinue telehealth services at any time if we believe that the videoconferencing sessions are not adequate for the situation. _____(initial)
6. I understand that the telehealth session will not be audio or video recorded at any time, unless I have been previously notified and have agreed to the recording.
7. I agree to permit my/ the client/parent/caregiver's healthcare information to be shared with other individuals for the purpose of scheduling and billing, if applicable. _____(initial)
8. I acknowledge that I have the right to request the following:
    - Omission of specific details of my the client/parent/caregiver's medical history that are personal or sensitive.
    - Termination of service at any time.
9. When the telehealth service is being used and an emergency occurs, I understand that it is the responsibility of the parent/caregiver to seek care from a local healthcare or professional and will not hold the Gulf Breeze ABA provider liable. Being it is a telehealth platform service, the Gulf Breeze ABA provider will not be able to intervene in case of an emergency. _____(initial)
10. It is the responsibility of the telehealth provider to conclude the service upon termination of the video conference connection.
11. I/ the client/parent/caregiver, understand(s) that it is my/ the client/parent/caregiver to pay the session fee at the time of scheduling. If, the client/parent/caregiver is a Florida Medicaid recipient, I/ the client/parent/caregiver understand the child's insurance will be billed by Gulf Breeze ABA for telehealth services (limited to 2 hours a week). I/ the client/parent/caregiver understand that if insurance does not cover telehealth services,

I/ the client/parent/caregiver will be billed directly by Gulf Breeze ABA for the provision of telehealth services. _____(initial)

12. My/ the client/parent/caregiver's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/ the client/parent/caregiver agree that there have been no guarantees or assurances made about the results of this service. _____(initial)
14. I/ the client/parent/caregiver acknowledge the telehealth program's no-show policy which states that I/the client/parent/caregiver will be discharged from the telehealth program if I/ the client/parent/caregiver no-show for 2 consecutive telehealth appointments, without prior contact to Gulf Breeze ABA. A $25 fee will also be assessed at the occurrence of a no-contact, no-show. _____(initial)
15. I confirm that I have read and fully understand the above and *Telehealth Practices Policy* provided. All marked spaces have been initialed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me. _____(initial)

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the Client/Parent/Caregiver Signature

Print Name

Date

*The signature of the the client/parent/caregiver must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to (including to treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the client/parent/caregiver fully understands what I have explained and answered.

Provider's Signature Date