Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Therapy Talk, Inc. (TT) as a part of the therapy process and my treatment goals for my child. I understand I have the following rights with respect to telehealth:

- I understand that "telepractice" includes diagnosis and treatment using interactive audio, video, or data communications. I understand that telepractice also involves the communication of my medical information, both orally and visually.
- I understand that the standard of care is the same whether the patient is seen in-person or through telepractice and that I will be notified immediately if it is determined that this delivery model is not appropriate for a patient.
- I have the right to withhold or withdraw consent to participate in telepractice at any time without it affecting my right to future care or treatment but that the care or treatment may not be available through TT.
- I understand that healthcare information may be shared with other individuals for the purposes of scheduling, billing, and in implementing a patient's plan of care and that these individuals involved will at all times maintain confidentiality of the information obtained and the laws that protect privacy and confidentiality of medical information equally apply to telepractice.
- I understand that I am responsible for providing the necessary computer, telecommunications equipment (camera and microphone) and internet access for my telepractice sessions.
- I understand that for certain patients, an adult facilitator will be required to be present in the room for assisting with technical difficulties, or keeping a patient on task.
- I understand that I am responsible for arranging a quiet location with sufficient lighting and privacy that is free from distractions or intrusions for the telepractice session to take place in.
- I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of TT. that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
- I understand that TT's "payment policy" is the same for telepractice appointments as in-person appointments. TT does not guarantee any payment by insurance companies. The patient is responsible for the payment of all services rendered. I understand that there are benefits, risks, and possible consequences associated with telepractice, including, but not limited to, the possibility, despite reasonable efforts on the part of TT, 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.

I have read and understand the information provided above and have had my questions answered to my satisfaction. I have read this document carefully, and understand the risks, benefits, and my rights related to the telepractice and I am hereby electively giving my informed consent to participate in a telepractice service by TT under the terms described herein. I hereby state that I have read, understood, and agree to the terms of this document.

_____ **Client's Name and Birth Date**

_____ **Signature of Parent/Legal Guardian/ DATE**

140 Cabarrus Avenue West Concord, NC 28025 704-239-6321cell 844-708-0619 fax
www.TherapyTalk.org Office@TherapyTalk.org