Communication Connection Speech Services
Live Video Visits Patient Consent/Refusal Form

Patient Name: _____DOB: _____

Parent/Guardian Name: _____Email: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in Live Video Visits in connection with Speech Therapy.
2. NATURE OF LIVE VIDEO VISITS: During the Live Video Visit:
    a. Expect face-to-face interaction between parent/caregiver and/or child with Speech Pathologist to promote development of speech/language/feeding skills.
    b. Details of my child's medical history, examinations, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.
    c. Only with my expressed consent, video, audio and/or photo recordings may be taken of me and/or my child for educational or informational resources.
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding my access to medical information and copies of my medical records apply to Live Video Visits. Dissemination of any patient-identifiable images or information for this Live Video Visit shall not occur without my consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with Live Video Visits, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. RIGHTS: I understand that my healthcare provider or I can discontinue the Live Video Visits if it is felt that the videoconferencing connections are not adequate for the situation. I may withhold or withdraw consent to Live Video Visits at any time without affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. RISKS, CONSEQUENCES & BENEFITS: I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
7. EMERGENCIES: Should an emergency arise, I understand that the responsibility of the Live Video Visits Therapist is to advise my local agency and that therapist's responsibility will conclude upon termination of the video conference connection. I understand that I may need to call "911" or other emergency number to get the help I may need.
8. CLINICIAN: I have had a direct conversation with my clinician to ask questions in regard to Live Video Visits. 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.

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 Live Video Visits.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Please Check ☑ Your Choice Below:

I ____ **agree** to participate in Live Video Visits.

I ____ **refuse** to participate in Live Video Visits.

Signature of Parent/Guardian: _____
Date: _____ Time: _____

Witness: _____
Date: _____ Time: _____