Child Name (first, last): _____

Parent/Guardian Name: _____ Date Signed: _____

SANTOSHA
WELLNESS

Phone 269-254-8130 | Fax 866-376-0467
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Please read all the following information carefully and sign/initial where indicated.

Telehealth is the utilization of electronic communication technologies by a therapist to deliver occupational and/or speech therapy services to a child when they are located at a different site than the therapist. Our office will be utilizing this type of therapy to provide occupational and speech therapy services, and services provided via telehealth will be held to the same standard as in-person services.

Please review the following statements and sign below to acknowledge your understanding and agreement with all the listed statements.

1. I understand that there are risks and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. Our office will be taking every step necessary to minimize any risk of disruption or breach of confidentiality. We will be utilizing doxy.me for all telehealth services, which is a fully HIPAA-compliant platform. Our email system, electronic medical records, and billing system are all also fully HIPAA-compliant and we utilize encryption software that is monitored by an IT company to further enhance our security.

2. I understand that there is an increased risk for misunderstanding when telephone or video conferencing since many of the non-verbal cues are significantly reduced. I will provide clarification if I think my child's therapist has not fully understood me and/or my child during a telehealth session. I understand that my child's therapist will likely periodically ask for clarification as well.

3. I understand that my child's therapist will ask me questions to ensure my child's identity at the beginning of each session (ie. Entering your child's name when prompted in the doxy.me waiting room).

4. I understand that there will be no recording of any of the online Telehealth sessions by either myself or my child's therapist unless I give written permission. All information disclosed within sessions and

written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted/required by law.

5. I understand that the privacy laws that protect the confidentiality of my child's protected health information (PHI) also apply to telehealth sessions unless an exception to confidentiality applies.

6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, my child's therapist will contact me via telephone or email to discuss options and/or rescheduling.

7. I understand that my child's therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. Please update your child's emergency contact below, as it may have changed since the onset of the COVID-19 pandemic and shift to online services.

Emergency Contact Name: _____ Relationship to child:_____

Emergency Contact Phone #: _____

I have read this document and understand the risks and benefits of telehealth services and have had my questions regarding the procedure answered. By signing below, I agree to all the above terms and to the commencement of telehealth services with the office of Santosha Wellness, LLC.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Printed Name of Parent/Legal Guardian Relationship to client