



Pediatric Therapy Services

1057 EAST HENRIETTA ROAD, SUITE 500 ROCHESTER, NY 14623

PHONES: 585.427.2977 • 585.427.7610

FAX: 585.427.7410

CONSENT FOR OUTPATIENT TELETHERAPY

I consent to have my child's therapy services delivered using Teletherapy. I understand that this method of service delivery via my commercial insurance may only be accessible during the current State of Emergency. This method of therapy involves interactive audio and video for the duration of the session.

1. The SLP, OT, PT explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
2. I understand that a teletherapy session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the teletherapy session if it is felt that the videoconferencing connections are not adequate for the situation.

TheraPlatform, GoToMeeting or doxy.me are the technology services we will use to conduct teletherapy appointments. By signing this document, I acknowledge:

1. These platforms are NOT Emergency Services and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, GoToMeeting, doxy.me, TheraPlatform or Step by Step provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. These services facilitate videoconferencing and are not responsible for the delivery of any healthcare, medical advice or care.
4. To maintain confidentiality, I will not share my teletherapy appointment link with anyone unauthorized to attend the appointment.

In addition, I also consent to the use of text and email without the use of encryption to communicate with my provider as it relates to my child's services. I am aware of all the potential risks.

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 the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Child's Name

Date of Birth

Parent/Guardian Signature

Date