



Teletherapy Consent Form

The American Speech and Hearing Association (ASHA) defines telepractice (the act of providing Telehealth services) as “the application of telecommunications technology to deliver professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation.” This means the therapist and the child would join a computer-based session at the designated therapy time and would work on the same materials as in the office. We term this “teletherapy.”

It is important to know that this service delivery model is support through the Florida licensing board, and the American Speech-language Hearing Association (ASHA). This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

I _____ hereby consent to engage in teletherapy with Diana G. Masker & Associates, Inc. (DGM). I understand that “teletherapy” includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on part of DGM, 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 understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and high speed internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and or intrusions for my teletherapy session.

Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties or keeping a child on task. Teletherapy may be used as the primary means of service delivery or may be used in combination with in-person services.

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

I have read, understand, and agree to the information above.

Patients Name (Printed)

Date

Patient/Guardian Name (Printed)

Patient/Guardian Signature

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