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BOLD Pediatric Therapy Center
TelePractice Consent Form

Patient Name: _____ DOB: _____

1. I understand that my therapy provider has recommended therapy be delivered at a distance by telePractice

2. It has been explained to me how the video conferencing technology will be used to deliver therapy services and it will not be the same as a direct face to face visit because I will not be in the same room as my therapist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telepractice session if it is felt that the videoconferencing connections are not adequate for the situation. We will attempt to reschedule the session when possible.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Another person may also be present during the consultation other than my therapist to assist in operating the video equipment or graduate student learning. These people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence and thus will have the right to request the following: (1) ask non-medical personnel to leave the telepractice therapy room: and or (2) terminate the consultation at any time.

5. I understand the alternative to telepractice therapy delivery, and I choose to participate in telepractice therapy visit. I understand that some parts of the session may require physical handling or physical assistance and may be conducted by another person at my location at the direction of the therapist. This will likely be a parent or caregiver. I understand that it may also be necessary to participate in periodic face to face service delivery on site at BOLD Pediatric Therapy Center to ensure continued appropriateness of care. I agree to periodic on-site sessions as provider license requires or need for evaluation.

6. I understand that billing will occur following the therapy session.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____
Patient's/parent/guardian signature Date Time

_____
Child signature (if appropriate)

_____ _____ _____
Therapist signature Date Time