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CONSENT FOR AUDIO AND/OR AUDIO CONSULTATION

I understand that my health care provider wishes me to engage in a video and/or audio sessions.

My health care provider explained to me how the video conferencing technology will not be the same as a direct client/health care provider visit due to the fact I will not be in the same room as my provider.

I understand that a video/audio session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that my health care provider or I can discontinue the video/audio session if it is felt that the video/audio is not adequate for the situation.

I have had a direct conversation with my provider during which I had the opportunity to ask questions in regards to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language I understand.

Zoom.us is the technology service we will use to conduct videoconferencing appointments. It is simple to use and there are no passwords required to log on. I will send an invitation that each person will receive by email.

By signing this document I acknowledge:

Zoom.us is not an emergency service and in the event of an emergency, I will use a phone to call 911.

Though my provider and I may be in direct virtual contact, Zoom.us does not provide any medical or healthcare services or advice including, but not limited to emergency or urgent medical services.

Zoom.us facilitates videoconferencing and is not responsible for any healthcare, medical advice, or care.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend this appointment.

I understand my provider may make additional videoconferencing services should the need arise.

I further understand that my provider has conducted due diligence to ensure these services are HIPPA compliant and sufficiently secure to warrant use for therapy services.

I certify that I have read this form or had this form explained to me.

I fully understand the contents including the risks and benefits of the procedures.

I have been given ample opportunity to ask questions and that these questions have been answered to my satisfaction.

_____ _____

Print Name: Patient (Parent/Guardian) Date:

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Signature: Patient (Parent/Guardian)