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INFORMED CONSENT FOR TELETHERAPY

A to Z Pediatric Therapy LLC

5825 Glenridge Dr., Bldg. 1, Suite 133

Atlanta, GA 30328

CONSENT FOR TELEHEALTH SERVICES:

1. I understand that my healthcare provider wishes me to engage in a telehealth appointment.
2. My healthcare provider explained to me how the video conferencing technology that will be used to affect such a visit will work during therapy sessions.
3. I understand that a telehealth appointment has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand 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 telehealth consult/visit/appointment if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY A TO Z PEDIATRIC THERAPY:

ZOOM VIDEO CONFERENCING is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. **ZOOM** is NOT an Emergency Service 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, neither **ZOOM** or **A TO Z PEDIATRIC THERAPY** provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The **ZOOM** Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the **ZOOM** Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the **ZOOM** Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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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.

_____ _____

Client Name **Date**

_____

Patient/Guardian Signature

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