Abilities in Action
Pediatric Therapy

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INFORMED CONSENT FOR ONLINE THERAPY/TELEHEALTH

This form is designed to allow you to give informed consent for the use of video technology for online therapy, known as telehealth. Read it thoroughly and ensure all of your questions are answered before signing to give consent. This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Telehealth is defined as the use of technology to conduct a therapy session. We will use Theraplatform, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely. Theraplatform uses encrypted data streams for our video sessions. Any data that is stored outside of our video session on the Theraplatform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

1. I understand that I will need a computer, tablet or mobile device that has audio and video using Chrome or Safari browser to participate in telehealth sessions. My child's therapist has explained to me how the video conferencing technology will be used to conduct a session and understand that it will not be the same as an in-person visit due to the fact that my child and I will not be in the same room as my therapist.
2. The benefit of telehealth is the ability for your therapist to provide continuity of care for your child. With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist, and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session.
3. I understand that my healthcare information may be shared with other individuals at Abilities in Action for consulting, scheduling and billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be notified of their presence in the consultation and thus will have the right to request the following: (1)omit specific details of my medical history/physical examination that are personally sensitive to me; (2)ask non-medical personnel to leave the room; and or (3) terminate the consultation at any time.
4. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation. I understand that some parts of the visit may involve stretches and exercises that will need to be performed by me or someone in my household under the direction of my child's therapist.
5. I understand that billing will occur from Abilities in Action, LLC.
6. If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.
7. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

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Consent to Treatment via Telehealth

Each telehealth/teletherapy visit will be approximately 45 minutes. I understand that my financial responsibility is $90 per telehealth session. I agree to pay Abilities in Action for the session on the day that the service is rendered, by phone or having a credit card on file. Abilities in Action will submit the claim to my insurance company. Any monies paid to you in excess of the $90 fee is due to Abilities in Action.

I understand that my child's therapist will be facilitating the session through telehealth and that I will be responsible for implementing the activities, exercises or strategies during the telehealth session.

I voluntarily agree to receive online therapy services for my child and authorize Abilities in Action to provide such care, treatment, or services as are considered necessary and advisable. I understand that I may withdraw consent for such care, treatment, or services that my child receives through Abilities in Action at any time. I understand that my child's therapist will determine on an on-going basis whether my child's condition is appropriate for online therapy.

By signing this Informed Consent, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this method of service delivery. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

Patient Name

Printed Parent, Guardian or Legal Representative Name

Parent, Guardian or Legal Representative Signature Date

**please complete, sign and email this page to info@abilitiesinaction.com*
** a clear picture of page 2 can be taken from your mobile device can be emailed as well*