



Speech/Language Therapy
Occupational Therapy
Social Groups/RDI®
Assessments
CST/MFR

Dear Parent,

Thank you for your interest in a Zoom therapy session. Attached is a consent form that you can sign electronically and return to us. Please let us know if you would like to speak by phone or email before signing the form. We are excited to have the opportunity to continue your child's therapy in spite of these changing times.

With appreciation,

The Team
at Peer Projects Therapy From the Heart

Informed Consent for Teletherapy

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my speech- language pathologist/occupational therapist/tutor wishes me to engage in a telehealth consultation.
2. My speech-language pathologist/occupational therapist/tutor explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
3. I understand that a telehealth consultation 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 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 ZOOM

Zoom Video Communications, Inc. 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 Video Communications, Inc. 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 Video Communications, Inc. or Peer Projects, LLC or Therapy From the Heart, LLC provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Zoom Video Communications, Inc. 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 Video Communications, Inc. 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 Video Communications, Inc. Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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.

Child's Name

Patient/Guardian if patient under 18

Date