24 Hollywood Blvd, Suite 7
Ft Walton Beach, FL 32548
Phone: 850-226-7411
Fax: 850-226-7496
www.treehousetherapies.net

Teletherapy Informed Consent Form

Child's name: _____ DOB: _____

I _____ (print name) hereby consent to engage in teletherapy (e.g., internet, email or telephone-based therapy) with my Treehouse Therapies, LLC OT/PT/Speech therapist as the main mode of treatment. I understand that teletherapy includes the practice of health care delivery, including OT/PT/Speech/Feeding Therapy delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that teletherapy also involves the communication of my child's medical information, both orally and visually, to other health care practitioners.

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.

(2) Teletherapy occurs in the state of Florida (USA), and is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist in their home, where we meet to complete therapy sessions.

(3) The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the above information.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____