INFORMED CONSENT FOR ONLINE THERAPY SERVICES

CONSENT FOR ONLINE SERVICES (read and acknowledge below)

1. I understand that my speech-language pathologist/occupational therapist wishes to conduct online video conferencing services.
2. It has been explained to me how the video conferencing technology will work during therapy sessions.
3. I understand that online therapy services have 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, and technical difficulties. I understand that my healthcare provider or I can discontinue the online services if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand my clinician may wish to record partial or full sessions for evaluation. I agree to this recording and to refrain from doing any recording or screen captures without my clinicians consent.
6. I have had a **direct conversation** with my clinician 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 ONLINE VIDEO-CONFERENCING SERVICES BY ZOOM

Zoom is the technology we use to conduct online video conferencing appointments. Participants must have a computer or tablet with internet access, a camera and microphone. Zoom is a HIPAA compliant platform. Online sessions cost the same rate as in-clinic sessions, with patient responsibility remaining the same as in-clinic services.

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, nor The Hello Clinic provide any medical advice/services relating to emergencies or urgent care.
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.
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, 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.

Print Patient Name (First, Last)	Signature: Patient/Guardian if patient under 18	Date