

[Sample] Consent Telehealth Consultation

[Insert name, address and contact information for your practice/school]

1. I understand that my [insert discipline-e.g., Physical Therapist, Speech Language Pathologist, Social Worker, Counselor, Therapist] recommends engaging in telehealth services with me to provide treatment.
2. I understand this is out of necessity and an abundance of caution and has originated due to the Coronavirus (Covid-19) pandemic. This will continue until such time that we are able to meet in person, or could continue, depending on the particular circumstance.
3. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.
4. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand; however, there is no guarantee that all treatment of all patients will be effective.
5. I understand that it is my obligation to notify my [insert discipline] of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my [insert discipline] of the change in location.
6. I understand that it is my obligation to notify my [insert discipline] of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my [insert discipline] at the outset of each session and am aware that confidential information may be discussed.
7. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.
8. I agree that I will not record either through audio or video any of the session, unless I notify my [insert discipline] and this is agreed upon.
9. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand

some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

10. I understand that my [insert discipline] is not responsible for any technological problems of which my [insert discipline] has no control over. I further understand that my [insert discipline] does not guarantee that technology will be available or work as expected.
11. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.
12. I understand that my [insert discipline] or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or my [insert discipline] that the videoconferencing connections or protections are not adequate for the situation.
13. I have had a conversation with my [insert discipline], during which time I have had the opportunity to ask questions concerning services via telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me.
14. [Name of the Telehealth Service to be used] is the technology service we will use to conduct telehealth videoconferencing appointments. My [insert discipline] has discussed the use of this platform. Prior to each session, I will receive an email link to enter the “waiting room” until the session begins. There are no passwords or log in required.

By signing this document, I acknowledge:

1. [Name of the Telehealth Service to be used] is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.
2. I recognize my [insert discipline] may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my [insert discipline] is concerned that immediate medical attention is needed.
3. Though my [insert discipline] and I may be in virtual contact through telehealth services, neither [Name of the Telehealth Service to be used] or my [insert discipline] provides any medical or emergency or urgent healthcare services or advice. I understand should medical services be required, I will contact my physician. If emergency services are needed, I understand I should call 9-1-1.

4. The [Name of the Telehealth Service to be used] facilitates videoconferencing and this technology platform is not, itself, a source of healthcare, medical advice, or care.
5. I understand that the same fee rates apply for telehealth as apply for in-person treatment. Some insurers are waiving co-pays during this time. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.
6. During these times of the impact of Coronavirus (Covid-19) my [insert discipline] may not have access to all of my medical/treatment records. My [insert discipline] has made reasonable efforts to obtain records, but I understand and agree this may not be reasonably possible.
7. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.
8. I understand that either I or my [insert discipline] can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

I have read and understand the information provided above regarding telehealth, have discussed it with my [insert discipline], and I hereby give informed consent to the use of telehealth.

Signature of patient (or guardian/conservator)

Printed name

Date