

**Informed Consent for Teletherapy Services**

**Introduction**  
Teletherapy involves the use of electronic communications and platforms for therapists to conduct therapy sessions for clients who are not physically in the clinic for the purpose of providing uninterrupted therapy services. This service delivery model is supported by the Florida licensing board, the American Speech-Language and Hearing Association (ASHA), and the American Occupational Therapy Association (AOTA). Telepractice is viewed as a mode of delivery of health care services, not a separate form of practice. The standard of care is the same whether the patient is seen in-person, through telehealth (telepractice), or by other methods of electronically enabled health care. Teletherapy is used for evaluation, therapy, follow-up and/or education, and may include any of the following: 1) Patient medical records, 2) Live two-way audio and video and/or, 3) Sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. AASL utilizes the Zoom Business platform for telepractice; our business agreement with the Zoom platform incorporates software security measures that meet HIPAA standards. This is the place to protect the confidentiality of patient identification and data, and protect against the aforementioned corruption.

**Expected Benefit**  
Allowance for continuity of care during times when a patient cannot access therapy in office for a multitude of reasons.  
  
**Possible Risks**  
Depending on web connections, bandwidth, and other automated intricacies, the connection may inhibit effective interaction; however, these deficiencies or failures are expected to be minimal. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. It must be recognized and understood that there are benefits, risks, and possible consequences associated with telepractice, including but not limited to, the possibility that the transmission of your information could be disrupted or distorted by technical failures, the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons. AASL has and will continue to monitor protocols and do everything to protect confidentiality.

**Attendance**

Please note that AASL’s attendance policies remain in effect and families are expected to attend regularly scheduled Teletherapy sessions with the same consistency as in-clinic visits. We suggest logging on five minutes prior to your visit to ensure on-time arrival and avoid incurring late fees. If you need to cancel or reschedule your Teletherapy session, a minimum of 24 hours’ notice must be provided to avoid incurring a cancellation fee. Also, note that a parent or caregiver must remain in attendance for the full duration of the Teletherapy session.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy, and that no information obtained in the use of teletherapy which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a teletherapy interaction and may receive copies of this information for a reasonable fee.

4. I understand that I may expect the anticipated benefits from the use of teletherapy in my care, but that no results can be guaranteed or assured.

5. I understand that it is required that I must remain in attendance with my child during the entire therapy session to help ensure the integrity of the appointment.

**Patient Consent To The Use of Telemedicine**

I have read and understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my child’s scheduled therapy appointments.

I hereby authorize All About Speech & Language to use telemedicine in the course of my diagnosis and treatment.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature of Patient (or person authorized to sign for patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If authorized signer, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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