Achieve Pediatric Therapy & Rehab
Teletherapy Informed Consent Form

I _____ (parent/guardian) hereby consent to engage in teletherapy with Achieve Pediatric Therapy & Rehab. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.
3. You understand that this teletherapy occurs in the state of Texas, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the therapist in his/her Texas office.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; and/or the transmission of my information could be interrupted by unauthorized persons.
5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to an in clinic visit. Finally, I understand that there are potential risks and benefits associated with any form of therapy.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.
8. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

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

_____
Parent/Guardian Signature

_____
Child's Name

_____
Date