Capitol City
Speech Therapy, LLC

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Capitol City Speech Therapy Teletherapy Consent Form

American Speech and Hearing Association (ASHA) defines teletherapy (the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech therapy services through digital meetings. The digital media will be completed via synchronous telecommunications system which includes audio and video services that are **HIPAA complaint for PHI. The therapist and the patient would join a computer -based session at the designated therapy time, and would work on the same materials as in the office. We term this "teletherapy." It is important to know that this service delivery model is supported through the NC licensing board, the American Speech-Language-Hearing Association (ASHA), and is payable some insurance carriers per the Telehealth Enhancement Act of 2013-H.R.3306, 113th Congress. This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

I _____(patient or legal guardian)hereby consent to engage in teletherapy with Capitol City Speech Therapy, PLLC. I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Capitol City Speech Therapy (CCST), 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 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.

Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task. Teletherapy may be used as the primary means of service delivery, or may be used in combination with in-person services.

**Exception: During COVID-19: Exception for COVID-19/HIPAA compliant technology might not be available: Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

I have read, understand and agree to the information.

_____ _____ _____

Patient Signature or Legal Guardian | Patient/Guardian (Printed name) | Date