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ADVANCE for kids
PEDIATRIC
Physical, Occupational, and Speech-Language Therapy

212 West 3rd Street
Rome, GA 30165
Phone: (706) 295-4242
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A Neurodevelopmental Center

Telehealth Consent Form

PATIENT NAME: _____
DATE OF BIRTH: _____
GA MEDICAID ID#: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telehealth service in connection with either one or more of the following: Occupational Therapy, Speech Therapy, or Physical Therapy
2. **NATURE OF TELEHEALTH SERVICE/DURING THE TELEHEALTH SESSION:**
    a. Details of your medical history, examinations, testing, and treatment will be discussed through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place.
    c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
    d. Video, audio, and/or photo recordings may be taken of you during the service
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth service. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth service and all existing confidentiality protections under Federal and Georgia State law apply to information disclosed during this telehealth session.
5. **RIGHTS:** You may withhold or withdraw consent to the telehealth services at any time without affecting your right to future care of treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telehealth service will be resolved in Georgia, and that Georgia Law shall apply to all disputes.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner or office representative has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth service. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth service for the therapy described above.

Signature: _____ Date: _____ Time: _____

If signed by someone other than the patient, indicate relationship:

Witness Signature: _____Date: _____ Time: _____