Telehealth Informed Consent Form

It is important that you, the client, read this consent form carefully and obtain answers to any questions that you may have.

Thank you for choosing Equipoise Occupational Therapy, PLLC for your care for occupational therapy.

Occupational Therapy: Occupational therapy involves several methods of evaluation and treatment. We use a variety of procedures and treatments to help us try and improve your physical and psychosocial function. As with all forms of medical treatment, there are benefits and risks involved. Patient responses to a specific form of treatment can vary widely from patient to patient, and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition.

You have the right to inquire as to the form of treatment based upon your history, diagnosis, and symptoms.
You may discuss with your provider the potential risks and benefits of a specific treatment and possible alternative treatment.
You have the right to decline treatment at any time or during your treatment sessions.
Your therapist will answer questions you may have regarding a given course of treatment, type of exercise or treatment method, associated risks, and possible alternatives.

In the event of Telehealth sessions or when electronic visits are appropriate:

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.
(2) Teletherapy is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist remotely.
(3) The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.
(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
(5) In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.
(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, 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 am responsible for information security on my computer or electronic device. I have read, understand, and agree to the information above.

This consent form is based upon your informed decision to participate in the proposed treatment plan for therapy services. My therapist has discussed with me in words that I can understand, my diagnosis, conditions, reasons for and benefits of the plan of care, the reasonable likelihood of success, the possible material risks of not following the pan of care, the possible risks associated with the plan of care, and possible alternatives and risks associated with those alternatives. My therapist and I have discussed my goals of recovery and potential problems that might arise during treatment. I have decided not to participate in alternative treatments at this time. I understand there are risks associated with therapy as described above. I am giving this consent with the understanding that any treatment or services involve some risks and hazards, and that no guarantees have been made to me.

I HEREBY CERTIFY THAT I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I DO NOT DESIRE ANY FURTHER EXPLANATION AND UNDERSTAND AND ACKNOWLEDGE THAT COMPLICATIONS CAN RESULT.

_____

Name of Patient/Authorized Legal Guardian

Date:_____

_____

Name of Provider obtaining consent