CONSENT TO PARTICIPATE IN A TELETHERAPY CONSULTATION/TREATMENT

1. I authorize and voluntarily consent to the participation and treatment of myself or child in a HIPAA compliant teletherapy consultation and/or treatment with Altruistic Therapy Services, LLC.

2. I understand that as a participating patient, my therapist and I will communicate by interactive (videoconferencing) through Altruistic Therapy Services, LLC. I understand that teletherapy is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments.

3. It has been explained to me how the video conferencing technology will be used to conduct a visit. I understand that this visit will not be the same as an in-person visit due to the fact that my child or loved one will not be in the same room as the healthcare provider at the distant site. I also understand that I have the option to see a provider in person, if I chose.

4. I further understand that there are potential risks to teletherapy, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand that either the healthcare provider or I can discontinue my child's or loved one's teletherapy visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand it may be necessary and useful for others to be present during the visit other than my child's healthcare team and provider in order to operate the video equipment. These individuals are bound to maintain confidentiality of all information obtained. I further understand that I have the right to request the following when nonmedical personnel are present to: (1) omit specific details of my child's medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the examination room; and/or (3) terminate the visit at any time.

6. During my child's or loved one's teletherapy visit, I understand that the responsibility of the teletherapy healthcare provider concludes upon the termination of the video conference connection and Altruistic Therapy Services, LLC is not responsible for the actions of the distant site.

7. Any interview, tape, film, or photograph made of my child / loved one will be used for medical purposes and maintained by Altruistic Therapy Services, LLC as confidential medical records, consistent with Federal and State law.

8. By signing this consent, I authorize my therapist to release any relevant medical information, pertaining to my child's / loved one's medical condition and medical care to Altruistic Therapy Services, LLC, its and healthcare professionals as it pertains to the case of those involved. I also authorize Altruistic Therapy Services, LLC, or its providers, to release any and all information to my insurance company or any other agent that may be responsible for paying my medical bills. I further understand and consent to being interviewed, taped, filmed, or photographed by my therapist and Altruistic Therapy Services, LLC.

9. I understand that I have the right to withdraw my consent at any time. If at any time I am not satisfied with the services rendered, I may file a complaint with the Altruistic Therapy Services, LLC team.

10. I have read (or have had read to me) this document carefully, and hereby consent to participate in the Teletherapy consultation/services under the terms described above.

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Signature Date