Center for Vocal Health, Inc.
TelePractice Patient Consent/ Refusal Form – Speech Therapy

Patient Name: _____ DOB: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a TelePractice Session in connection with the following procedures/purposes: Speech Therapy
2. NATURE OF TELEPRACTICE CONSULT: During the telepractice session:
    a. Details of your medical history, tests, diagnosis may be discussed with you and other health professionals through interactive audio-video connection.
    b. A trained technician (medical or non-medical) may be in the telepractice studio with you while you are evaluated and treated.
    c. The therapist will administer various dynamic screenings, examinations and therapeutic tasks and techniques within their scope of practice.
3. MEDICAL INFORMATION AND RECORDS: All applicable laws regarding your access to medical information and copies of your medical record applies to this telecommunication session. Please note, not all telecommunications are recorded.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made for patient confidentiality during your telecommunication session. All existing confidentiality protections apply to this telepractice session.
5. RIGHTS: You may withhold or withdraw consent to the telepractice session at any time.
6. RISKS & BENEFITS: You have been advised of all the possible risks and benefits of this telepractice session. You have had the opportunity to ask about information on this form as well as your telepractice session. All your questions have been answered, and you understand the written information you were provided.
7. INSURANCE: It is up to you, the patient, to verify your speech therapy telehealth benefits prior to participating in televisit sessions. Not all insurance covers telehealth/teletherapy sessions. If you participate in the service and your insurance does not pay for such service via telehealth, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

I agree to participate in the telepractice sessions described above.

Patient Name (Print): _____

Signature: _____

Date: _____