All About Kids, Inc.
Pediatric Therapy Services
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Informed Consent for the Use of Virtual Therapy Services

Child Information:

Name of Child:	Child ID#	Date of Birth (mm/dd/yyyy)
Street Address:	City	Zip Code

Therapy Service Type (check all that apply)

☐ Evaluation and Assessment ☐ Ongoing Treatment ☐ Individualized Family Service Plan (IFSP)

Therapy Discipline (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Acknowledgement and Statement of Consent

I understand that my child and family may receive PHYSICAL/OCCUPATIONAL/SPEECH THERAPY services through virtual visits. I also understand that federal and state laws require I consent to the following:

1. I consent to the delivery of pediatric therapy services by virtual visits over a computer, tables, or smart phone between All About Kids Pediatric Therapy Services professionals and my family/child. I understand that the availability of virtual visits will depend of the type of technology, devices, or system requirements used. I understand that the most secure delivery and receipt method is wired computer, less secure is using Wi-Fi and the least secure is using cellular data.

2. I understand that pediatric therapy professionals will have the same licensure/certification and apply the same standard of care as therapy professionals during an in-person visit.

3. I will have access to all therapy records and information resulting from the sessions conducted through virtual visits as I would during in person visits, and as provided for by law. <u>I agree to keep a written record of each virtual encounter with my therapist.</u>

4. As with any internet-based communication, I understand the risks include the possibility of technological problems with may result in poor quality or disconnection from the virtual visit, as well as a security breach without the appropriate protections. To help mitigate security risks, it is recommended I take steps to protect my personal device and date including using a secure Wi-Fi network with password and using a videoconferencing platform with end-to-end encryption to participate in virtual visits.

5. In understand that All About Kids Pediatric Therapy Services is not responsible for my device security and acknowledge and knowingly accept the risks of accessing service(s) via virtual technology.

6. I understand that, in addition to the therapy professional, other individuals may be involved in the virtual visit to operate or repair the video or audio equipment. If this occurs, these individuals must be identified to all parties in the visit and must adhere to the same privacy policies as the therapy professional.

7. I understand that I am responsible for the cost of technology associated with receiving therapy services through virtual visits (e.g. data/internet plans, personal device).

8. I understand that the use of virtual visits are only allowable/payable at this time due to COVID-19 and are not a permanent service delivery option. This temporary policy will be in effect until Georgia's public health emergency is lifted. Future telehealth visit continuation after the COVID-19 health crisis will be considered on a case-by-case basis, if applicable.

Telehealth Terms of Service

1. Billing for the telehealth visit will be at the same rates as an in-person visit. You will be responsible for any copays, co-insurance, or deductibles as per your insurance contract. If your child is enrolled in the Georgia Babies Can't Wait program, all current billing rules apply, including billing for Family Cost Participation, if applicable.

2. All existing laws regarding your access to medical information and copies of your medical record apply to this telehealth encounter. Not all communications are recorded or stored.

3. You may withhold or withdraw consent to the telehealth encounter at any time without affecting your right to future care or treatment.

4. You agree that any dispute arriving from the telehealth encounter will be resolved in Georgia, and that Georgia law will apply to all disputes.

5. By participating in a telehealth encounter, you consent to participate in a telehealth appointment visit under these terms.

Signature of parent/guardian/caregiver	Date (mm/dd/yyyy)	Time
Witness	Date (mm/dd/yyyy)	Time
Signature of Therapist	Date (mm/dd/yyyy)	Time