**Informed Consent for Provision of Teletherapy Services**

This document shall be reviewed and agreed to prior to the initiation of teletherapy services (as used in this Consent, the

term “teletherapy” also includes “telepractice” and “telehealth” services).

**Definition of Teletherapy Services:** Teletherapy services involve the use of electronic communications to enable

providers to connect with individuals using live interactive video and audio communications, as well as electronic mail

communications. Teletherapy services include the practice of consultation, referral to resources, education (direct

services), and the transfer of data. Services will be discussed with families prior to the start of teletherapy. It is the

parent/guardian’s responsibility to ensure that a support person (e.g. parent, guardian, caregiver) is available to guide

the student during teletherapy services. Depending on the student’s needs and skill set, some forms of teletherapy may

not occur without an available support person. Students must be located within Delaware for teletherapy services to

occur.

**Teletherapy Responsibilities:** I understand that I am responsible for: (1) ensuring that the student is located within

Delaware when teletherapy services are being provided, (2) having accessible the necessary computer,

telecommunications equipment and/or internet access for teletherapy sessions, (3) the information security on my

computer, (4) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for

teletherapy sessions, and (5) assisting the student directly or arranging for a designee to assist the student with

connecting to the agreed upon platform to participate in the teletherapy services as well as providing assistance to the

student during the teletherapy services, as appropriate. It is the responsibility of the participants and any listeners to

maintain confidentiality of all parties participating in the teletherapy session, including during group therapy sessions.

**Teletherapy Services Risks:** While service providers will provide services and maintain confidentiality to the best of their

abilities, there are risks and limitations of (1) use of electronic communications and provision of care and specific

skills/services that can be addressed remotely, (2) the potential breach of confidentiality, or inadvertent access, of

protected health information using electronic communication in the provision of care, and (3) the potential disruptions

of electronic communication in the use of teletherapy.

**Teletherapy Service Rights:** I understand that I have the following rights with respect to teletherapy services:

(please check each box if you understand and agree to the terms below…)

☐ I understand I have the right to withhold or withdraw my consent for the use of teletherapy services at any time,

without affecting the student’s right to future instruction or services.

☐ I understand that there are risks and consequences from teletherapy services, including, but not limited to, the

possibility, despite reasonable efforts on the part of the staff member, that: the transition of my personal information

could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted

by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or

accessed by unauthorized persons.

☐ By signing this document, I agree and consent to the use of electronic communications in the provision of

services/care.

☐ By signing this document, I agree that I will not record the Teletherapy session via audio and/or video recording.

☐ By signing this document, I agree to maintain the confidentiality of other students, if my child is participating in a

group lesson. (Remember that all individuals participating will likely see and hear what is occurring in your home, just as

you may see and hear what is occurring in their home).

☐By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for

audio/video/computer-based services. If my child or I am in crisis or in an emergency, I should immediately call 9-1-1 or

seek help from a hospital or crisis-oriented health care facility in my immediate areas.

I have read and agree to the responsibilities required to participate in teletherapy services, have been made aware of the possible risks and limitations of teletherapy services, and consent to the provision of teletherapy (or telepractice/

telehealth) services.

|  |
| --- |
| Name of Parent/Guardian: |
| Name of Student: |
| Parent’s Email Address: |
| Parent’s Phone Number: |
| Signature of Parent/Guardian: | Date: |

**Agreement to Sussex Montessori Public Charter School’s Informed Consent for Provision of Teletherapy Services may**

**be indicated by signing and emailing or scanning the above form to your student’s related service provider.**

**Alternatively, agreement can be provided by emailing the above information and the following statement to your**

**student’s related service provider:**

*I have reviewed the teletherapy service agreement and I agree to and acknowledge the*

*terms of the agreement. My electronic signature shall be considered a signature for purposes of execution and*

*delivery of this document.*

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* Each therapist providing services to the name student will sign