LAKESHORE
SPEECH THERAPY, LLC.

CONSENT FOR TELEPRACTICE

1. I understand that my health care provider wishes me to engage in a telepractice. 2. My health care provider explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider. 3. I understand that a telepractice session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. 4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telepractice session/visit if it is felt that the videoconferencing connections are not adequate for the situation. 5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. GOOGLE MEET is the technology service we will use to conduct telepractice video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge: 1. This is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911. 2. Though my provider and I may be in direct, virtual contact through GOOGLE MEET, neither GOOGLE MEET nor the provider gives any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. 3. GOOGLE MEET facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. 4. I do not assume that my provider has access to any or all of the technical information in GOOGLE MEET – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in GOOGLE MEET. 5. To maintain confidentiality, I will not share my telepractice appointment link with anyone unauthorized to attend the appointment. By signing this form, I certify: That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____/_____

Signature Date