

Consent to Telehealth Services

Practice Information

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1. Purpose

This form is designed to provide you with information about telehealth services and obtain your informed consent to participate in remote mental health care.

Telehealth services are provided by a Florida-licensed psychologist and are governed by the laws and professional regulations of the State of Florida. If the client or parent/legal representative is physically located outside Florida at the time of a session, services may not be provided unless permitted by applicable law. It is the responsibility of the parent or legal representative to inform the provider if the client will be temporarily or permanently located outside the State of Florida during the course of services.

2. What Is Telehealth?

Telehealth refers to the use of secure video, phone, or other communication technologies to provide mental health services remotely. This can include therapy, assessments, and consultations. In accordance with Florida Statute §456.47, telehealth services are provided only through secure, HIPAA-compliant technology.

3. Services Provided via Telehealth

Mental health services that may be delivered via telehealth include:

- Individual, family, or group therapy
- Psychological assessment and consultation
- Parent guidance and support
- Neuropsychological testing (when clinically appropriate, technically feasible, and consistent with test publisher requirements, standardization procedures, and validity considerations).
- Clinical interviews (e.g., parent, caregiver, teacher, or client interviews)
- Developmental and behavioral consultation
- Structured or semi-structured diagnostic interviews
- Intake and feedback sessions for psychological or neuropsychological evaluations
- Functional and academic accommodations consultation
- Remote behavioral observations

4. Benefits and Risks of Telehealth

Benefits:

- Increased access to care, especially for those in remote or underserved areas
- Greater scheduling flexibility, including reduced travel time and costs
- Comfort of receiving care in a familiar environment
- Potential for family members or caregivers to more easily participate in sessions

Risks:

- Possible disruptions due to technical issues, including internet connectivity problems or software glitches
- Limited ability to observe subtle body language, facial expressions, or environmental factors
- Potential risks to confidentiality despite security measures (e.g., someone else in your location overhearing sessions)
- May not be appropriate for all individuals or clinical situations, such as emergencies or severe behavioral issues
- Challenges in building rapport or therapeutic alliance for some clients
- Risk of misunderstandings due to audio or video delays or poor quality
- Possible limitations in performing certain types of assessments or interventions remotely
- Certain tests or procedures may not be administered remotely if test validity cannot be ensured

In the event of a technology failure (e.g., loss of video or audio connection), the provider may attempt to reconnect, continue the session by phone when clinically appropriate, or reschedule the session. Telehealth sessions are subject to the same attendance, cancellation, and fee policies as in-person services, as outlined in the Financial Responsibility and Payment Policy.

5. Alternatives to Telehealth Services

You have the right to receive care in a format that works best for you. Alternatives to telehealth include:

- In-person sessions
- Referral to another provider or clinic for in-person care
- Hybrid care (combination of in-person and telehealth), when suitable

6. Confidentiality and Its Limits

Information shared during sessions is kept private and confidential in accordance with HIPAA and applicable Florida law. Telehealth sessions are not recorded or stored by the provider unless specifically agreed upon in writing. Any recording of telehealth sessions would require explicit written agreement in advance and is not permitted by default.

Confidentiality may be limited or information may be disclosed without written authorization (consent) under the following circumstances:

- When a parent or legal representative provides written authorization to release information to another party (e.g., school personnel, physicians, therapists, or insurance companies)
- If the patient expresses thoughts, intent, or plans to seriously harm themselves or another person
- If the provider has reasonable cause to believe that a child, an elderly person, or a dependent adult is being abused, neglected, or exploited
- If disclosure is required by a valid court order, subpoena, or other legal process
- If the patient meets criteria for involuntary psychiatric evaluation or hospitalization due to safety concerns
- If the provider consults with other professionals for purposes of treatment planning, supervision, or coordination of care, only the minimum necessary identifying information will be shared
- If services are requested, authorized, or funded by a third party (such as a school district, legal agency, or court), relevant information may be shared in accordance with the agreed-upon purpose. Schools and external providers do not receive evaluation reports or clinical information without a valid written authorization, unless disclosure is otherwise required by law

For minor clients, parents or legal representatives generally have the right to access the patient's records. In certain situations, limited information may be handled with clinical discretion when appropriate to support treatment, safety, or therapeutic effectiveness, as permitted by law.

While all efforts are made to use secure, encrypted platforms, telehealth services carry some risks related to technology, including the potential for unauthorized access to electronic communications, technical failures, or breaches of privacy. This could result in personal information being accessed by unauthorized parties. It is important to ensure you are in a private space when participating in telehealth sessions to protect your confidentiality.

A complete description of privacy practices and confidentiality limits is provided in the Notice of Privacy Practices.

7. Emergency Protocol

Telehealth is not appropriate for managing emergencies. If you or the patient is experiencing a mental health crisis:

- Call 911
- Go to the nearest emergency room
- Call the 988 Suicide & Crisis Lifeline
- Contact a local crisis center or mental health provider

For safety purposes, the practice must have (1) an emergency contact other than the parent or legal representative attending the telehealth session, (2) an alternative phone number for the attending parent/legal representative, and (3) the patient's current physical location at the start of each telehealth session.

Emergency Contact (Required – must be someone other than the parent/legal representative attending the session)

Name:

Relationship to Client:

Phone Number:

Parent/Legal Representative Attending Telehealth Session

Name:

Primary Phone Number:

Alternative Phone Number (required):

The Physical Location of Patient and Parent/Legal Representative Attending During Telehealth Session (Required)

Patient's Physical Location

Street Address:

City:

State:

ZIP Code:

Parent/Legal Representative's Physical LocationStreet Address: City: State: ZIP Code: **8. Voluntary and Right to Refuse Services**

- Participation in telehealth services is completely voluntary
- You may choose not to begin or to stop telehealth at any time
- You may request an alternative treatment option such as in-person sessions or a referral
- Choosing not to use telehealth will not affect your ability to access other types of care available through this provider or another

9. Client Rights

As a client, you have the right to:

- Be treated with respect and dignity
- Receive clear information about your care
- Ask questions about the telehealth process
- Withdraw your consent at any time
- Receive appropriate referrals or alternatives when needed
- File a complaint without fear of retaliation

10. Recording Policy

Recording of telehealth sessions by the client or any other party is strictly prohibited without the explicit written consent of the provider. This policy is in place to protect your privacy, maintain confidentiality, and preserve the integrity of the therapeutic process. Unauthorized recording may violate laws and ethical guidelines.

11. Technology and Privacy

We use HIPAA-compliant platforms to provide telehealth services and communicate securely with you. These include our electronic medical record (EMR) system and Zoom for Healthcare Providers. Both platforms employ security measures to protect your privacy and confidential health information.

12. Telehealth Session Etiquette

To help ensure a smooth and effective telehealth session, please:

- Find a quiet, private space free from distractions
- Use headphones when possible to protect your privacy
- Minimize background noise and interruptions
- Ensure your device is fully charged or plugged in
- Test your internet connection and technology before the session
- Avoid multitasking during the session to stay fully engaged
- Inform the provider if any other individual is present in the room or able to hear the session; undisclosed third-party presence may affect confidentiality and clinical validity

13. Consent to Telehealth Services

By signing below, you acknowledge that:

- You have read and understood this form
- You understand the nature of telehealth services
- You understand the risks and benefits of telehealth
- You are aware of alternatives to telehealth
- You understand the limitations to confidentiality
- You are participating voluntarily and may stop at any time
- You understand your client rights
- You understand our recording policy
- You consent for yourself or the patient to receive services via telehealth

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgement (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have received, read, and understood the Consent to Telehealth Services of Pediatric Neuropsychology Associates PLLC. I confirm that I am the parent/legal representative of the patient named below, that I have the authority to consent on their behalf, and that I voluntarily consent to telehealth services as described above.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed form will be retained in the patient's health records.

For Office Use Only

Date Received:

Received By:

Staff Role:

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: