Treehouse Pediatric Therapy
12201 Gayton Road
Henrico, VA 23238
(804) 794- 7337 PEDS
(804) 794-7399 FAX
treehousepediatrictherapy@gmail.com

Teletherapy Informed Consent

Introduction

Teletherapy is the form of healthcare care that uses audio-video conferencing tools to connect a healthcare provider and patient who are not at the same location.
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient health information and will include measures to safeguard the data and to ensure its integrity and privacy against intentional or unintentional corruption and unauthorized access.

Expected Benefits:

Benefits of teletherapy include alternative access to therapy by enabling a client to remain in his/her home and receive evaluation and treatment.

Possible Risks:

Potential risks associated with the use of this technology include interruptions, unauthorized access and technical difficulties.
By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to teletherapy, and that no information obtained in the use of teletherapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that my teletherapy sessions will not be recorded by me or my provider without both of us giving consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained in the course of a teletherapy interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of care may be available to me, and that I may choose one or more of these at any time.
6. I understand that it is my duty to inform my provider of any other healthcare providers involved in my medical/psychiatric care.
7. I understand that I may expect the anticipated benefits from the use of teletherapy in my care, but that no results can be guaranteed or assured.

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Client Consent To The Use of Teletherapy

I have read and understand the information provided above regarding the benefits and risks of teletherapy. I have discussed the contents of this form with my provider or another as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my health care.

I hereby authorize Sensational Play LLC/ Sensory Play LLC, or Treehouse Pediatric Therapy, LLC to use teletherapy in the course of my diagnosis and treatment.

Signature of Client (or person authorized to sign for Client): _____

*Date:*_____

Printed Name of the Client: _____

*If authorized signer, relationship to patient:*_____

*Witness:*_____ *Date:*_____

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Teletherapy Payment Policy

Invoices will be sent out weekly. Payment is due in full upon receipt of invoice. **Payment can be received via bank transfer, credit card, or Zelle.** Initial _____

We do not accept insurance as payment for services. However, after payment has been made to Sensational Play LLC, Sensory Play LLC, or Treehouse Pediatric Therapy, LLC and after services have been rendered, then we can provide you with an itemized monthly receipt for you to submit to your insurance company. Since insurance companies vary widely in their reimbursement for out-of-network providers and in their reimbursement for teletherapy, we in no way guarantee that you will receive any reimbursement. If the insurance company requires supporting documentation from us, we will be happy to provide that to you. We recommend that you talk at length with your insurance company prior to making a commitment to your therapy session here so that you have an idea of what your final out of pocket expense will be. Initial _____

Invoices for outstanding balances on accounts greater than one week will result in therapy being put on hold. The child will be placed on the wait-list until payment is received. Initial _____

Invoices for outstanding balances on accounts greater than 30 days will be charged an additional $25 late fee per month. Accounts with balances after 60 days will be charged an additional 25% of the current outstanding balance to cover collection agency fees. The guardian/parent will be responsible for any additional costs associated with a collection agency. Initial _____

OT and Speech Teletherapy Rates (as of March 15, 2020):

55 minutes teletherapy = $95.00

45 minutes = $80.00

25 minutes = $55.00

AAC Rates- 55 minutes= $110, 45 minutes=$90, 30 minutes= $65

Teletherapy Initial Consult Rates (as of April 1, 2021):

Initial Speech-Language Consult Rate (55 minutes) = $150.00

Initial Occupational Therapy Consult Rate (55 minutes) = $150.00

Initial Feeding Consult Rate (55 minutes) = $150.00.

Initial AAC Consult Rate (55minutes)= $175

I agree with the rates, payment policy, and outstanding balance policy as listed above.

_____ _____

Parent Signature/ Date