AUTHENTIC HEALTH LLC

Pediatric OT
Informed Consent for Virtual Services

Name of Child: _____ Date of Birth: _____

I understand that my child and family will receive 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 OT services by virtual visits over a computer, tablet, or smart phone between Authentic Health LLC and my family/child. I understand that the availability of virtual visits will depend upon the type of technology, devices, or systems requirements used, including but not limited to interactive video, audio or data communication.
2) I understand that the OT professional will have the same licensure certification and apply the same standard of care as provided in an in-person visit.
3) I will have access to all OT records and information resulting from the sessions conducted through virtual visits as I would during in person visits, as provided for by law.
4) I understand that Authentic Health LLC is not responsible for my device security and acknowledge and knowingly accept the risks of accessing service(s) via virtual technology.
5) I understand that I am responsible for the cost of the technology associated with receiving Pediatric OT visits through virtual means (data internet plans, personal devices).
6) I agree not to hold Authentic Health LLC liable for technical failure during the service provided.
7) I have been provided with the opportunity to ask questions, and those questions were answered to my satisfaction.
8) I understand that I can refuse, change my mind or withdraw consent for virtual visits at any time. I agree to notify my practitioner of such decisions for as long as I receive services from that provider.

_____ _____

Signature of Parent/Caregiver Date

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