



## A Better Tomorrow Therapy & Wellness Center, LLC

### Informed Consent for Tele-Health Services

I understand that Tele-Health is used when it is not advisable or available for me to visit A Better Tomorrow Therapy and Wellness Center, LLC in person. Reasons to use Tele-Health may include but are not limited to cases of emergency, illness, quarantine, transportation issues associated with remote locations, travel restrictions, illness, or a residential move until local services are made available.

I understand that the rules of confidentiality in Tele-Health are the same as the rules of confidentiality stated in the ABTAK HIPAA Patient Information Form I have read and signed prior.

I understand that the laws protecting the privacy of my child's medical information also apply in Tele-Health.

I understand that the HIPAA Patient Information form I previously read and signed also apply in Tele-Health.

I understand that the information used for evaluation, therapy, follow-up and/or education, may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand that no electronic media is perfect and on occasion, breaches of privacy may occur with Tele-Health.

I understand that because A Better Tomorrow Therapy and Wellness Center, LLC. is licensed by and located in the State of Alaska, that Alaskan laws apply to the standards of care and to the handling of my child's medical records.

I understand that it is my responsibility to help make my Tele-Health therapy sessions successful.

I agree to the best of my ability to arrange a safe, quiet, private place with lighting and internet connection in which to participate in my Tel-Health appointment.

I agree to have my telephone near me (and charged if a cell phone) during my child's sessions as a backup should there be a disruption in video service due to technical difficulties.

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### Patient Consent to the Use of Telemedicine

As the parent / legal guardian of \_\_\_\_\_, I give my permission for A Better Tomorrow Therapy and Wellness Center, LLC to use Tele-Health as a means of providing for my child's therapy needs.

I have read and understand the information provided above regarding tele-health. I hereby give my informed consent for the use of Tele-Health in my child's medical care. I understand that if Tele-Health proves unsuitable for my child's therapy needs, I can decline future Tele-Health visits without jeopardizing my future access to direct in-office visits with ABTAK.

Parent's / Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_