Up & Pediatric Therapy Movin' PC

TELEHEALTH CONSENT FORM

I hereby consent for my child to participate in telehealth therapy visits provided by staff from Up & Movin' Pediatric Therapy, PC. Telehealth visits will be provided via a secure HIPPA compliant platform (DoxyMe) between myself and my child and their therapist. Provider will provide therapy from a secure private area to maintain patient confidentiality during sessions. Services will be provided for the authorized time frame that is equal to their clinic-based visit times. I am aware that the therapist cannot diagnose illnesses or prescribe medication. I have been informed of my child's therapy goals, the areas in which they need to work, and their service plans. I will be available during the telehealth session to observe and learn strategies to carry out home program ideas.

_____ _____

Child's Name **Child's DOB**

_____

Parent Name **Parent Signature** **Date**

6180 Brockton Ave. Suite 102, Riverside CA 92506
Office Phone (951) 684-6500
Office Fax (951) 684-0051
pedtherapy@upandmovintherapy.com

Up & Pediatric Therapy Movin' PC

6180 Brockton Ave. Suite 102, Riverside CA 92506
Office Phone (951) 684-6500
Office Fax (951) 684-0051
pedtherapy@upandmovintherapy.com