Indiana University Speech and Hearing Clinics
Consent for Telepractice Services

Patient Name: _____

Name of Legal Guardian (if applicable):_____

Date Range of Telepractice Appointment: _____

Please read this consent and the attached guidelines for telepractice appointments and sign below where indicated, Return the signed copy via email or IU Speech and Hearing Clinic 200 S. Jordan Ave., Bloomington, IN 47405.

1. I understand that I will be participating in a telepractice appointment with the Indiana University (IU) Speech and Hearing Clinic. This appointment will include a licensed audiologist or speech-language pathologist and graduate student clinicians. I understand that the IU Speech and Hearing Clinic is part of the IU Department of Speech, Language and Hearing Sciences.
2. I understand that the benefits to a telepractice appointment include having access to healthcare and education without having to travel to the IU Speech and Hearing Clinic.
3. I understand that following this telepractice appointment, one or more in-person appointments may still be necessary depending on my specific needs or due to any technical problems.
4. I understand that multiple telepractice appointments may be part of my treatment plan in the Speech-Language Clinic.
5. I have had the alternatives to telepractice explained to me, and I am choosing to participate in a telepractice appointment.
6. My audiologist/speech-language pathologist has explained to me how the video conferencing technology that will be used to affect such services will not be the same as direct patient/provider services due to the fact that I will not be in the same room as my clinician. I understand that the technology may not work efficiently or be interrupted. In the event that the session is interrupted, there will be an agreed upon backup plan (e.g., text or phone call).
7. While IU has implemented appropriate privacy and security safeguards for this telepractice appointment, I understand there are potential risks to this technology, including interruptions by unauthorized persons, unlawful access to my medical information by unauthorized persons, and disrupted or distorted transmission of information by technical difficulties.
8. I understand that I am responsible for arranging a location to complete the telepractice appointment that has sufficient lighting, quiet and is free from distractions or intrusions.
9. I understand that I am responsible for providing the essential computer or other device, technical equipment (web-camera, microphone, and speakers), and Internet access to participate in the telepractice appointment.
10. I understand that an adult other than myself may be required to be present in the room during the telepractice appointment to assist with technical difficulties or other matters related to the appointment.
11. I understand that my audiologist/speech-language pathologist or I can discontinue the telepractice appointment if it is felt that the videoconferencing connections are not adequate for the situation.
12. I understand that my healthcare information will be maintained to the same privacy standards as an in-person appointment but may be shared with others for scheduling and billing purposes.
13. I may withhold or withdraw my consent to the telepractice appointment at any time without affecting my right to future care or treatment.
14. I understand that certain speech/language pathology telepractice services may be free-of-charge until August 1, 2020. I will not receive any bills for these telepractice sessions during this period. These complementary telepractice services are limited in scope. I acknowledge that charges for these telepractice services will resume on August 1, 2020. Free audiology telepractice services are limited to and may include, if appropriate, hearing aid checks, hearing aid consultations and hearing aid evaluations through August 1, 2020. Products (e.g., amplification devices, accessories, hearing aid batteries) will be charged at usual and customary rates.

15. I will have a direct conversation with my audiologist/speech-language pathologist, during which I will have the opportunity to ask questions regarding these services as well as the costs that may be associated.
16. My questions will be answered and the risks, benefits, and any practical alternatives that are discussed with me will be in a language in which I understand.
17. Prior to my appointment, I understand that my audiologist or speech language pathologist will create an emergency plan and that I will need to identify an emergency contact and phone number, address and phone number for my location during the telepractice appointment in the event that emergency services need to be called.
18. I understand that my audiologist or speech language pathologist is a mandatory reporter. I understand that consultations, test results and disclosures between my practitioner and myself will be confidential in accordance with state law. I understand that there are exceptions to confidentiality and include the following: 1) I threaten to harm myself or someone else, 2) illegal activity is occurring (such as abuse or neglect of an elder or minor), 3) if health care records are subpoenaed or if there is legal action regarding the therapy.
19. I understand that due to the importance of confidentiality and the importance of minimizing dual relationships, friend or contact requests on any social networking site (Facebook, LinkedIn, Instagram, Twitter, Snapchat, Periscope, Google +, etc) will not be accepted. I understand that adding me as friends or contacts on these sites can compromise my confidentiality and our respective privacy and may also blur the boundary of our professional relationship.

By signing this form, you certify:

1. That you are physically present in the State of Indiana during the telepractice appointment.
2. That you are over the age or 18 or the legal guardian of the patient being seen in this telepractice appointment.
3. That you have read or had the consent form and guidelines read and/or explained to you.
4. That you fully understand their contents, including the risks and benefits of telepractice.
5. That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

Signature: _____ Date: _____

Printed Name: _____

May 7, 2020