Amaryllis
THERAPY NETWORK

Permission for Telemedicine Services

Amaryllis Therapy Network has always been a child and family centered clinic. We understand that there are times where face to face contact might not be in your family's best interest. With that thought in mind we are going to offer telemedicine services which will include OT/PT/ST services with your current therapist. In order to be able to provide these services we need your permission to waive the face to face requirements by insurance. Please initial next to each line and then sign this document.

____ 1. I am aware that I retain the option to refuse the delivery of health care services via telemedicine at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which my child would otherwise be entitled.

___ 2. All applicable confidentiality protections shall apply to the services given through telemedicine.

___ 3. I will have access to all medical information resulting from the telemedicine services as provided by applicable law to my/my child's medical records.

Child's Full Name: _____
(Please Print)

Parent/Guardian's Full Name: _____
(Please Print)

_____ _____
Parent/Guardian's Signature Date