West Virginia University
CENTER FOR EXCELLENCE IN DISABILITIES

# Authorization and Consent to Participate in Telehealth Services

1. **Purpose and Benefits:** The purpose of this consent form is to establish or maintain access to music therapy services when face-to-face contact is restricted or not available.
2. **Nature of Music Therapy Telehealth Services:**
    a. Details of your/your child's medical history, music therapy assessment, or other details may be discussed through the use of interactive video, audio and telecommunications technology.
    b. Services provided via telehealth: music therapy consultations and individual music therapy sessions
    c. Non-medical personnel may be present in the telehealth studio to assist with video transmission.
    d. Video, audio, and/or digital photo may be recorded during the telehealth visit.
3. **Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records apply to telehealth visits. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
4. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telehealth visits. All existing confidentiality protections under federal and West Virginia law apply to information disclosed during telehealth visits.
5. **Risks and Consequences:** Telehealth visits will be similar to typical visits, except interactive video technology will allow you to communicate with the music therapist at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to professional contact.
6. **Rights**: You may withhold or withdraw consent to telehealth visits at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
7. **Policies**:
    a. To establish music therapy care of any kind, clients will be required to complete the provided documents: Notice of Privacy Practices, Media Consent, Release of Information to Internal and External Agencies, and the Complaint Process.
    b. Scheduling:
        i. If the current session time needs to be changed, inform the MT and plan for a new schedule at least one week in advance of the desired session time/frequency.
        ii. If you need to reschedule or cancel, inform the MT in advance.
        iii. Cancellation or rescheduling of a session without any prior notice will incur a no-show fee. While it is understood that emergencies happen, more than two instances of no-notice cancellation may result in discharge from therapy services.
        iv. A contingency plan will be put in place if clients experience technology or equipment failures during telemedicine sessions.
        v. If the music therapist is absent, they are obligated to offer a make-up session.
        vi. If the client is absent, the music therapist is not obligated to offer a make-up session. However, all measures will be taken to keep scheduled sessions on track.

8. **Financial Agreement.** Telehealth sessions will be billed in the same manner as in-person sessions.

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Telemedicine Questionnaire:

1. Do you have a reliable internet and computer, iPad/tablet, or cellphone with video?
2. If you are exclusively using a cellphone for telemedicine, do you have data restrictions?
3. Do you have any accessibility requests, such as….?
4. Will you need personal assistance to complete telemedicine sessions?
    a. Are those individuals able to sign a HIPAA confidentiality agreement?

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# Music Therapy Telemedicine Consent Form

Client name: ___________________________________________________________

1. I understand that my music therapist wishes me to engage in a telemedicine session through the Center for Excellence in Disabilities.
2. My music therapist has explained to me how the video conferencing technology will be used.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my music therapist or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. If, for any reason, there are people other than my music therapist present for the telemedicine session, those people are expected to adhere to HIPAA and confidentiality standards and will have completed the necessary paperwork prior to the session. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my medical history/treatment plan that are personally sensitive to me; (2) ask non-music therapy personnel to leave the telemedicine room: and or (3) terminate the session at any time.
5. I have been informed of and understand the scheduling policies, billing policies, and client expectations for telemedicine music therapy sessions.
6. I have had a direct conversation with my music therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____________________________________________ ____________ ____:____ a.m./p.m.

Client/parent/guardian signature Date Time

_____________________________________________ ____________ ____:____ a.m./p.m.

Witness signature Date Time

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