UW Speech and Hearing Clinic
UNIVERSITY OF WISCONSIN–MADISON

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Teletherapy Informed Consent

I have been informed and understand the limitations of telepractice as a delivery option for speech language pathology, and audiology. I have been informed and understand the details of the proposed related assessment and intervention program via telepractice designed for myself and/or my child; including but not limited to the time, frequency and duration of the service, technical needs and protections, and the individuals involved in the delivery of services.

I have been informed and understand that I have the option to refuse telepractice as a service delivery option. I have read and understand this informed consent form and have had the opportunity to discuss it with a licensed speech language pathologist or audiologist.

☐ I consent to myself and/or my child receiving the above services via telepractice from a licensed and properly credentialed professional.

☐ I DO NOT consent to myself and/or my child receiving the above services via telepractice from a licensed and properly credentialed professional.

Name of client: _____

Name of parent/guardian (if client is a child): _____

Signature of client or parent/guardian of client: _____
Typing your name in this space serves as your electronic signature

Date: _____