Informed Consent for Telehealth Services

Patient Name: _____

Patient Address: _____

D.O.B.: _____

Practice Name: _____

Purpose: The purpose of this form is to obtain your consent to participate in a Telehealth Consultation and/or Treatment for your physical therapy program.

1. I understand that this session will not be the same as an in-person session, due to the fact that I will not be in the same room as my Physical Therapist or Physical Therapist Assistant, and will not be provided any hands-on examinations, assessments, or treatments.

2. I understand that there is a possibility of technical difficulties including but not limited to, poor image resolution, interruptions, and disconnection.

3. I understand that all existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent.

4. I understand that reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth treatments, and all existing confidentiality protections under state and federal law apply to information disclosed during this telehealth consultation.

5. I understand that when using electronic communication like Telehealth, in rare instances there is the possibility of a breach of confidentiality, or inadvertent access to, my Protected Health Information.

6. I understand that neither the above named practice, nor any of its Business Associates shall be held responsible for the loss of Protected Health Information, medical information, or any other personal information lost due to technical failure.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature: _____ **Date:** _____
Patient (or person authorized to give consent)

Relationship to Patient: _____

Clinician: _____ **Date:** _____

Witness: _____ **Date:** _____