BACK IN MOTION
PHYSICAL THERAPY

Telehealth Consent Form

This form is to obtain your consent to participate in telehealth physical therapy.

Nature of Telehealth session: Details of your medical history will be discussed, your status will be evaluated and you will be treated through the use of interactive video, audio, and telecommunication technology. Video, audio, and/or photo recording may be taken of you during the telehealth consult for coaching or treatment purposes only. Your therapist will determine whether your specific clinical needs are appropriate for a telehealth encounter.

Benefit: Improved access to care by enabling you to remain in your home while receiving physical therapy.

Possible Risks: Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies. In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Medical Information & Records: All existing laws regarding your access to medical information and copies of your records apply to this telehealth session. Healthcare information may be shared with other individuals for scheduling and billing purposes. Identifiable images or information for this telehealth interaction will not be shared with any other parties without your consent. You will not record the telehealth session (audio or video recording) unless given the consent of your therapist.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth sessions, and all existing confidentiality practices under state and federal law apply to information disclosed during this session

Rights: You may withhold or withdraw your consent to the telehealth consultation at any time for any reason. You do not have to give a reason for withdrawing from telehealth and it will not affect your right to future care or treatment. If you experience a medical emergency, you will be directed to dial 9-1-1 immediately.

Patient Consent: I have read this document carefully and understand the risks and benefits of the telehealth consultation and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein.

_____ _____
Patient Name (printed) Date

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date