



TELEMEDICINE and E-VISIT PATIENT CONSENT FORM

DATE:

PATIENT NAME:

DATE OF BIRTH:

PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine and E-visit physical therapy consultation and treatment.

NATURE OF TELEMEDICINE or E-VISIT CONSULT: During the telemedicine consultation the therapist will utilize interactive video, audio and telecommunication technology to:

Discuss your medical history, Conduct an assessment and Instruct you in a treatment plan that may include instruction in self manual therapy techniques, activities of daily living, therapeutic exercise, breathing exercises and other pain management techniques.

I understand that my health care provider wishes me to engage in a telemedicine consultation.

My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.

In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

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PATIENT INITIALS:

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I understand that billing will occur from my practitioner.
I have had a direct conversation with my physical 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.

Patient's/parent/guardian signature

Witness signature

Date Time

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