MOSAIC
physical therapy

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 TELEMEDICIINE 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.

PATIENT INITIALS:

11835 W. Olympic Blvd. Suite 135E Los Angeles, California 90064
Ph: 310-401-6410 Fx: 310-312-3637

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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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