Telehealth/E-visit Patient Consent/Refusal Form

Patient Name: _____ Date of Birth: _____ / _____ / _____

Purpose: The purpose of this form is to obtain your consent to participate in a Telehealth Consultation/Treatment or E-visit follow up in connection with the following procedure(s) and/or service(s):

-Physical Therapy Telehealth Treatment, E-visit follow up

1. Nature of Telehealth Consult/e-visit: During the telehealth consultation/e-visit:

a. Details of your medical history, examinations, x-rays, and tests will be discussed with health care professionals through the use of interactive video, audio, and telecommunication technology.
b. A digital physical examination may take place.
c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
d. Video, audio, and/or photo recording may be taken of you during the procedure(s) or service(s) for treatment/reimbursement purposes only.

2. Medical Information & Records: 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.

3. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telehealth consultation, and all existing confidentiality protections under state and federal law apply to information disclosed during this telehealth consultation.

4. Rights: You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment.

5. Risks, Consequences, & Benefits: You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care provider has discussed with you the information provided above.

6. In the event of an emergency occurring during the visit, I agree that the provider may contact emergency services. All fees associated with care resulting from that call to emergency services are my own responsibility and Summit Physical Therapy, Inc. is not responsible for these associated fees. In the case of an emergency,

my physical address is:_____

Please initial the following:

_____I agree to participate in telehealth care/e-visits with Summit Physical Therapy, Inc. for the procedure(s) and/or service(s) above.

_____I agree to video/photo capture of visits to be used only for treatment/reimbursement purposes.

_____I understand that my insurance will be billed for above services. Previous agreement regarding payment if insurance does not cover this service remains in place.

Signature: _____ Date _____ / _____ / _____ Time: _____ AM PM

If signed by someone other than the patient, indicate the relationship: _____