Informed Consent for Telehealth Services

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

THERAPIST NAME: _____ FACILITY NAME: **Perform! Physical Therapy**

Introduction

Telehealth involves the use of electronic communications to enable health care providers to evaluate and treat patients at remote and separate locations. Providers may include primary care practitioners, specialists, and/or subspecialists. Patient information may be used for diagnosis, therapy, and follow-ups, and may include any of the following:

- ➢ Patient medical records
- ➢ Medical images
- ➢ Live two-way audio and video
- ➢ Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- ➢ The ability to continue treatment while remaining socially distant from the practitioner's office, which includes staff and other patients, in order to minimize the risk of contracting and/or spreading COVID-19, caused by the SARS-CoV-2 coronavirus, and other contagious airborne illnesses.
- ➢ Efficient and effective medical evaluation and management.
- ➢ Obtaining expertise of a distant specialist.

Possible Risks

- ➢ In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider and patient(s);
- ➢ Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

By signing this form, I understand the following

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information that may be obtained and recorded in the course of a telehealth interaction.
4. I understand that it is my duty to inform my therapist of electronic interactions regarding my care that I may have with other healthcare providers.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth. I hereby give my informed consent for the use of telehealth in my continuing medical care.

I hereby authorize _____ (name of therapist) to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient: _____