Patient Consent for Telehealth Services

PATIENT INFORMATION

First Name:		**MI:**	**Last Name:**
DOB:	**Age:**		**Today's Date:**

CONSENT FOR TELEHEALTH SERVICES *(Initial Below*

_____ I understand that I will be engaging in Telehealth with Physical Therapy San Pedro for my physical therapy evaluation and/or treatment sessions.

_____ It has been explained to me how the video conference technology will be used to conduct my physical therapy session and that there will not be direct patient/physical therapist contact due to the fact that I will not be in the same room as my physical therapist.

_____ I understand that there are potential limitations using this technology, including interruption, unauthorized access and technical difficulties. I understand that my physical therapist and/or I can discontinue the Telehealth session if it is felt that the videoconferencing connection is not adequate for the situation.

_____ I understand that my healthcare information may be shared with other Physical Therapy San Pedro staff for scheduling and billing purposes. The above-mentioned staff will maintain HIPAA confidentiality.

_____ The alternatives to a Telehealth session have been explained to me, and in choosing to participate in Telehealth session, I understand that some parts of the exam/therapy visit involving physical test/activities/ exercises may require the assistance of a caregiver/family member/ friend at my location at the direction of my physical therapist to conduct and /or gaurd me as the patient to ensure my safety.

_____ I understand that Physical Therapy San Pedro and my physical therapist responsibility of me, the patient, for a given session will conclude upon the termination of the video conference connection.

_____ I understand that Physical Therapy San Pedro will bill my session as usual to my insurance provider(s) as a physical therapy visit with the addition of using modifier codes to indicate my session was performed virtually using video conferencing technology.

_____ I have had a direct conversation with Physical Therapy San Pedro staff and /or my physical therapist, during which I had the opportunity to ask questions in regard to my physical therapy. 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.

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Patient Name: **DOB:**

I, THE PATIENT OR RESPONSIBLE PARTY OF THE PATIENT, HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS CONTAINED HEREIN: *(Initial Below)*

_____ *I acknowledge I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.*

_____ *I acknowledge I fully understand its contents including the risk and benefits of Telehealth physical therapy sessions*

Patient's Name

Patient/Guardian Signature

Legal Guardian Name/Association

Date