Telehealth Patient Consent Form/ Refusal Form

Patient Name: _____

Patient Address: _____

Date of Birth: _____/_____/_____

Purpose: The purpose of this form is to obtain your consent to participate in a Telehealth Consultation/ Treatment with La Plata Physical Therapy in connection with the following procedure(s) and/ or service(s).

1. **Nature of Telehealth Consult: During the telehealth consultation:**
   a. Details of your medical history, examinations, x-rays, and tests will be discussed with other 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 purposes only.

1. **Medical information & Records**: All existing laws regarding your success 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 entitles shall not occur without your consent.
2. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth consultation, and all existing confidentially protections under state and federal law apply to information disclosed during this telehealth consultation.
3. **Rights**: You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment.
4. **Risks**, **Consequences & Benefits**: You have been advised of all potential risks, consequences and benefits of telehealth. Your health care provider has discussed with you the information provided above.

I agree to participate in telehealth care with La Plata Physical Therapy & Wellness for the procedure(s) and/ or service(s) above.

Signature: _____ **Date**:____/____/____ **Time**:_____ **AM/PM**
If signed by someone other than the patient, indicate the relationship: _____

Witness Signature: _____ **Witness Name in Print**: _____
Date: ___/____/____ **Time**:_____ **AM/ PM**