FINE TUNED
PHYSICAL THERAPY

Patient Name: _____ **Date of Birth: _____**

Informed Consent for Telehealth Services

Telehealth is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when they are located at a different location from the provider. Electronically transmitted information may be used for diagnosis, therapy, follow-up, and/or patient education; and it may include any of the following:

1) Patient medical records.
2) Medical images.
3) Interactive audio, video, and/or data communications.
4) Output data from medical devices and sound and video files.

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

Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1) Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for an appropriate therapy session to be conducted.
2) For certain cases, the physical therapist may not be able to perform all services under a telehealth session.
3) Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4) Security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand and agree to the following:

1) The laws that protect the privacy and confidentiality of medical information also apply to telehealth. No information obtained during a telehealth encounter which identifies me will be disclosed to researchers or other entities without my consent.
2) I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3) I have the right to inspect all information obtained and recorded during the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4) A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My therapist has explained the alternative care methods to my satisfaction.
5) I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

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FINANCIAL RESPONSIBILITY

In consideration for the telehealth services rendered to me, I agree to pay for all telehealth services rendered at the time of service. If services are paid for in part or full by insurance, then those payments will be credited to my account. I also understand that my plan may not cover telehealth, and so I am agreeing to self-pay for this service should my plan not offer this benefit.

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care. I hereby consent to and authorize Fine Tuned Physical Therapy to use telehealth in the course of my diagnosis and treatment.

_____ _____

Patient/Parent or Guardian Signature Date