



Telehealth Patient Consent Form

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

Patient Address: _____

1. The purpose of this form is to obtain consent to participate in a telehealth physical therapy consultation that may be in addition to, or separate from traditional in person sessions.
2. During the telehealth consultation(s), details of your medical history, examinations, diagnostic imaging/testing will be reviewed and discussed with your physical therapist through the use of HIPAA secured video and audio telecommunication technology.
3. Your physical therapy will perform an evaluation or treatment by instructing you in a series of motions as well as observing you complete prescribed exercises with the intent of making sure proper technique is being performed.
4. Any existing laws and policies regarding your access to medical information and copies of your medical records will apply to this telehealth evaluation and subsequent treatments. No video recording will be made without your knowledge and any dissemination of any patient identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent. Still photos may be take with your consent.
5. We are trying to assure all reasonable and appropriate efforts have been made to eliminate any confidential risks associated with your telehealth consultation but using HIPAA compliant Telehealth software. All existing confidentiality protections under state and federal law apply to information disclosed during this telehealth evaluation or treatment.
6. You may withhold or withdraw your consent to the telehealth at any time without affecting your right to future care or treatment.
7. You have been advised of all the potential risks, consequences and benefits of telehealth.

I hereby do agree to participate in telehealth physical therapy evaluation and treatments with Blackstone Valley Physical Therapy per the conditions above.

Signature: _____ **Date:** ___/___/_____

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