Informed Consent for E-Visit/Telehealth Services

Patient Name_____ **Date of Birth** _____

Location of Patient (address) _____

Date Consent was Discussed: _____

Physical Therapist's Name: Inna Keselman DPT OCS OTR/L

Occupational Therapist's Name: Inna Keselman DPT OCS OTR/L

Introduction

Telehealth involves use of electronic communication to enable healthcare providers at different locations to share individual patient medication information for the purpose of improving patient care. Provider includes physical or occupational therapist (PT/OT). The information may be used for physical or occupation therapy evaluation (non-Medicare patients only), management, treatment, follow-up and/or education, and may include any of the following:

· Patient Medical Record

· Medical Images

· Live two-way audio and/or video PT/OT sessions

· Output from m sound and video files.

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

Expected Benefits:

· Improved access to physical or occupational therapy care by enabling a patient to remain at his/her home while the physical or occupational therapist consults from healthcare practitioner's distant office.

· More efficient and consistent physical or occupational therapy management and treatment.

Possible Risks: There are potential risks associated with the use of telemedicine:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate PT/OT decision making.

· Delays in therapy management and treatment could occur due to deficiencies or failures of the equipment.

· In very rare instances, security protocols could fail, causing breach of privacy of personal medical information.

By Signing this Form, I Understand the Following:

1. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information 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 authorization.
3. 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.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My therapist has explained the alternative to my satisfaction.
6. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. 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.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my therapy care.

I hereby agree to assessments and/or treatments via telehealth with _____

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