Telehealth Patient Consent/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 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 ad telecommunication technology.
    b. A physical examination for 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).
2. 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 entities shall not occur without your consent.
3. 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.
4. Rights: You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment.
5. Disputes:
6. Risks, Consequences & Benefits: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care provider has discussed with you the information provided above.

I agree to participate in Endurance Rehab Telehealth Health Care for the procedure(s) and/or service(s) above.
I understand that my insurance may NOT pay for this visit. If they do not pay, I agree to pay $65 per Telehealth visit with my Physical Therapist.

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