TELEHEALTH CONSENT FORM

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).

NATURE OF TELEHEALTH CONSULT:

- All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications may be recorded and stored in this platform. 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.
- Video, audio and/or photo recording may be taken of you during the procedure(s) or service(s) not to be shared without your consent.
- Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth consultation, and all existing confidentiality protections under state and federal law in compliance with HIPPA apply to information disclosed during this telehealth consultation.

POTENTIAL BENEFITS:

I understand that my physical therapist cannot make any promises nor guarantees regarding a cure for, or improvements in my condition. My physical therapist will educate me on potential results of treatment for my condition and will discuss treatment options with me before I consent to care. Usual benefits may include a decrease in my symptoms and an increase in my ability to perform my daily activities. I may experience strength and flexibility gain, heightened endurance and improved body awareness. I should gain a greater knowledge about managing my condition and the resources available to me.

POTENTIAL RISKS:

As with any health care procedure complications may arise during the course of treatment. Adverse effects may include but are not limited to possible increase in my current level of pain discomfort, or aggravation with an existing injury. This discomfort is usually temporary, but if it persists or if I do not tolerate any part of my prescribed interventions I agree to inform my physical therapist. I am aware that I may be advised to seek an in person physical examination in combination and/or replacement for telehealth treatment.

PAYMENT:

I understand that this telehealth service may not be covered by my insurance plan and I agree to be responsible for charges up to $100 per visit.

INFORMED CONSENT FOR TREATMENT:

The term “Informed Consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. I understand all procedures will be thoroughly explained to me before they are performed and any questions will be addressed to my satisfaction. Having been informed of the risks, I hereby give my consent to treatment. I understand that I am able to decline any part of my therapy program at any time. If pregnant or trying to conceive, I authorize my practitioner to administer treatment during my pregnancy. I allow this consent form to cover the entire course of treatment for my present condition and for future conditions(s) for which I seek treatment. By consenting below, I acknowledge that I have weighed the risks involved in undergoing treatment and have determined it is in my best interest to proceed with the treatment recommended. This consent will be in effect for 1 year from the date of endorsement.

I have read the above consent for Quinn Orthopedic Physical Therapy Telehealth Services. I agree to participate in G Suite Telehealth for the procedure(s) and/or service(s) above. My signature below acknowledges that I have understood and will abide by the conditions and policies noted on this consent form.

I attest that I will be in California during the time that I am receiving the Telehealth physical therapy service.

Patient Name/Responsible Party: _____ Date: _____

Parent/Guardian (if applicable): _____

Signature: _____