Telehealth Informed Consent

Patient's
Initials

____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of New Jersey at the time of this service.

____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), or Medicare, and it is my responsibility to check with my insurance plan to determine coverage.

____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

____ I agree that information exchanged during my telehealth visit will be maintained by the healthcare facility (Foundations Physical Therapy) involved in my care.

____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

____ I understand that a physical therapy evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including follow up with a physician if deemed appropriate by my physical therapist.

____ I understand that my healthcare provider may choose to forward my information to an authorized third party, such as my primary care or referring physician. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

____ By signing this consent, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing 911 services in my community.**

____ I certify that I have read and understand this agreement and that any questions I had prior to signing have been answered by my rendering healthcare provider.

I understand that due to the state of the current national emergency crisis, telehealth is offered by **FOUNDATIONS PHYSICAL THERPY** to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our Physical Therapists at **FOUNDATIONS PHYSICAL THERAPY**.

_____ _____

Patient/ Legal Representative Signature Date