Elite
THERAPY SOLUTIONS

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.

You will be receiving your treatment via TELEHEALTH secure online platform. Telehealth sessions are hands -off sessions and will consist of detailed discussion regarding your condition, visual assessment of my movement patterns, balance, and range of motion. You will be given a home exercise program and advice to allow you to progress towards your goals.

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 and telecommunication technology.
b. A physical examination may take place.
c. Video, audio and/or photo recording may be taken of you during the procedure(s) or service(s).

1. 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.
2. 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.
3. Rights: You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment.
4. 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 telehealth services for the procedure(s) and/or service(s) above.

Signature: ____ Date: ___/____/_____

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

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