designing fitness
physical therapy

Telehealth Patient Consent Form

Patient Name: _____ Date of Birth:_____

1. **Purpose:** The purpose of this form is to obtain your consent to participate in a telehealth evaluation and telehealth services provided by your therapy provider.

2. **Nature of Telehealth Consult and Services:** During the telehealth consultation and services:

    - Details of your medical history and physical status will be discussed with you through the use of interactive video, audio, and telecommunication technology.

    - A physical assessment of you may take place.

3. **Video and audio recordings:** Video and audio recordings will not be taken of your session, unless you elect to record the session. If you elect to record the session, notify your therapist via email before the session.

4. **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth services, and to comply with all existing confidentiality protections under federal and state law to information disclosed during this telehealth consultation.

5. **Rights:** You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care or treatment, or risk the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **Risks, Consequences, & Benefits:** You have been advised of all the potential risks, consequences, and benefits of telehealth. Your therapist has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation and services. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation and/or services described above.

Signature:_____ Date:_____

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