CONSENT TO TELEHEALTH TREATMENT

Patient Name:_____

The purpose of this form is to obtain your consent to participate in a telehealth evaluation, telehealth treatment and/or e-visits (communication and treatment via phone or email) for outpatient therapy services with a licensed therapist from **G OOD CORE PHYSICAL THERAPY, LLC.**

The nature of a telehealth physical therapy sessions may include:

● The therapist will use a HIPAA Compliant, interactive video/audio communication platform to treat you.
● The therapist may perform a "virtual" examination via live video and audio feed.
● The therapist will not be able to perform hands on treatment such as manual therapy. A telehealth visit may not substitute for all your therapy needs and the therapist may advise you to undergo in person physical therapy treatment with them when/where available.

Expected Benefits Include:

● Improved access to therapy services from the convenience of patient's home

● Expert guidance from a licensed clinical Doctor of Physical Therapy for tissue healing and the development of an individualized treatment program. ● Efficient physical therapy intervention delivery with proven statistical success when compared to traditional therapy sessions.
● Continued progress on your therapy plan of care
● Minimized risk of exposure to respiratory viruses for high-risk populations

Risks:

● In rare cases, information transmitted (i.e. a poor video connection) may not be sufficient to allow for appropriate clinical decision making by the therapist.
● Technical difficulties could result in a missed or incomplete visit

● Delays in evaluation or treatment may occur due to equipment deficiencies or failure.

Medical Information and Records:

All existing laws regarding your access to medical information and copies of your medical records apply to these telehealth visits. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient information.

Confidentiality:

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with a telehealth visit, and all existing confidentiality protections apply to information disclosed during our telehealth visits.

Rights:

You may withdraw consent to telehealth visits at any time without affecting your right to future care or treatment.

I have read and understand the information provided above regarding therapy telehealth visits. I understand its contents including the risks and benefits. I have discussed the applicability of telehealth to my plan of care, and my questions have been answered to my satisfaction.

Signature:_____ Date:_____