Providence Physical Therapy
Women's Health ◆ Orthopaedics ◆ Spine ◆ Pelvic Floor Rehabilitation

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 consultation with your physical therapist.

2. METHOD OF THE TELEHEALTH CONSULT: Your consultation with your physical therapist will be done via telephone. Your physical therapist will call you at a number that you provide. The caller's telephone number will not be identifiable, so you should ensure that calls with "No Caller ID" will come through to your phone.

3. NATURE OF THE TELEHEALTH CONSULT: During the telehealth consultation your physical therapist will possibly discuss the results of your previous examination, recent changes to your health status and/or previous treatment, and will be able to answer questions you have about your current symptoms and strategies to self-manage/self-treat those symptoms. The physical therapist will also be able to provide education and make recommendations about home exercise and provide home exercise progression.

4. COST OF THE TELEHEALTH CONSULT: The cost of a 30-minute telehealth consultation is $60.00. This fee is payable at the time of scheduling the appointment and is not billable to your insurance company. Providence Physical Therapy will not be able to produce CPT (billing) codes for you to submit to your insurance company for reimbursement. This telehealth service is a cash pay service only.

5. MEDICAL RECORDS/INFORMATION: A brief case note that summaries the telehealth visit will be added to your medical record. All existing laws regarding your access to your medical information and copies of your medical records apply to this telehealth consultation. The telephone conversation will not be recorded.

6. CONFIDENTIALITY: Your provider will make every reasonable and appropriate effort to eliminate any confidentiality risks associated with the telehealth consultation. It is recommended that you do the same to protect your privacy while communicating on the telephone with your provider.

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

8. RISKS, CONSEQUENCES AND BENEFITS: You have been advised of all of the potential risks, consequences and benefits of telehealth. You have had the opportunity to ask questions about the information presented in this form and the telehealth consultation. All of your questions have been answered and you understand the written information presented above.

I agree to participate in a telehealth visit as described above.

______________________________________ ______________________

Signature (Electronic signatures accepted) Date