FYZICAL Therapy & Balance Centers

Informed Consent for Telemedicine Services

Date:_____

Patient name:_____

DOB:_____

Location of Patient:_____

Physician Name:_____

Physician Location:_____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Thomas DiPaolo, PT, DPT providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances, that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Dr. Thomas DiPaolo, PT, DPT at 732-587-5656 or Thomas.dipaolo@fyzical.com. As long as this consent is in force (has not been revoked), Dr. Thomas DiPaolo, PT, DPT may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient:_____ Date:_____
(or person authorized to sign for patient)

If authorized signer, relationship to patient:_____

Witness:_____ Date:_____

I understand that I may have a copy of this consent form if requested *(patient's initials)*:_____