Informed Consent for Telemedicine Services

PATIENT NAME: _____ DATE OF BIRTH: _____

LOCATION OF PATIENT : _____

THERAPIST NAME: _____ LOCATION OF THERAPIST: _____

DATE CONSENT DISCUSSED: _____

I understand that telehealth (also referred to as 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 FYZICAL Therapy & Balance Centers - Dewitt providing health care services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.

I understand that my insurance carrier will have access to my medical records for quality review/audit, as would normally occur with an in-person session.

I understand that I will be responsible for any co-payments or coinsurances that apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth 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:

FYZICAL Therapy & Balance Centers - Dewitt
12800 Escanaba Drive, Suite 3
Dewitt, MI 48820
Phone: 517-669-7228
Fax: 517-669-5675
Email: dewitt@FYZICAL.com

As long as this consent is in force (has not been revoked) FYZICAL may provide health care services to me via telehealth without the need for me to sign another consent form.

_____ _____

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

_____

If authorized signer, relationship to patient

I have been offered a copy of this consent form. _____

(patient's initials)

_____ _____

Witness Date