IDEAL MOTION PHYSICAL THERAPY

Telemedicine Patient Consent / Refusal of Treatment Form

I understand that telemedicine uses electronic communications to enable health care providers to assess, treat, and provide care for a patient in a separate location.

I understand that I have the right to consent to *and/or* withdraw my consent to the use of telemedicine in my treatment plan at any time.

I understand that while many treatments and therapies can be offered via telemedicine, it has limitations as well. I understand that my physical therapist will not have the ability to manually examine me and that this may limit their ability to fully assess my current condition.

I understand that my physical therapist will be making their treatment decisions based on my description of my symptoms and how I am feeling. I understand the importance of accurately describing how and what I am feeling. I understand that while a telemedicine visit may be helpful, it will not be equivalent to direct patient care by my physical therapist.

Confidentially:
All federal and state laws regarding medical records and information apply to telemedicine.

I understand that all available efforts will be taken to maintain the confidentially of all personal and medical information. Network and software security protocols will be used to safeguard all electronic interactions.

I understand that despite these efforts there is a risk of security failure and a breach of privacy with my personal and/or medical information.

I understand that Ideal Motion Physical Therapy will follow all state and federal laws in notifying me should a breech of my information occur.

Medical Records:
All laws regarding your access to your medical records apply to telemedicine as well.

I understand that Ideal Motion Physical Therapy will not being saving or recording these sessions but will make the therapist's written notes from these sessions available upon my request.

I acknowledge the above risk and benefits of telemedicine- ***I consent for Ideal Motion Physical Therapy to use telemedicine as a part of my treatment plan.*** I authorize Ideal Motion Physical Therapy to furnish information to other providers, healthcare or treatment facilities and my insurance companies for the purposes of treatment, payment and healthcare operations. I hereby assign to the provider all payments for medical services rendered to myself and/or my dependents.

_____
Name (printed)

_____ _____
Signature Date

After reading the above risk and benefits of telemedicine, I acknowledge that I have been offered telemedicine services but at this time ***I refuse the use telemedicine as a part of my treatment plan at this time***.

_____
Name (printed)

_____ _____
Signature Date