Consent for Telehealth Services

Patient Name:_____**Date of Birth:**_____

The purpose of this form is to obtain your consent to participate in a telehealth consultation/ treatment for outpatient therapy services with a licensed therapist from Empower Physical Therapy & Aquatics Institute. Please note that participating in a telehealth session is strictly voluntary. You may choose to have a face to face visit if services are being offered at our facility and you are not a Coronavirus risk to other patients and/or our staff. You can, of course, obtain therapy from any provider that could see you face to face.

Information about Your Telehealth Therapy Visit:

- Your therapist will, typically, use a HIPAA compliant, interactive video/audio communication platform to treat you. However, to expedite treatment and assure continuity of care the federal government has relaxed some of HIPAA's Rules during the Covid-19 Emergency. This allows us to use various virtual communication tools, like *Facetime*, that would not, under normal circumstances be permissible. We will answer any questions you have about our use of telehealth prior to initiating it unless you tell us otherwise.
- Your therapist may perform a "virtual" examination in addition to rendering treatment in the telehealth visit
- Your therapist will not be able to perform hands on treatment such as manual therapy so the telehealth visit may not be able to address all your therapy needs until a physical visit to our clinic is possible.

Expected Benefits Include:

- You can continue having therapeutic intervention by a licensed therapist when traveling to our clinic is not possible
- You can continue with your established plan of care so that you may continue to improve or, minimally, maintain functionally

Risks:

- Possible loss of records from failure of electronic equipment
- Possible power failure with loss of communication
- Possible invasion of electronic records from outsiders (hackers)
- Possible diminished ability of the therapist to detect functional changes that might have been detected during an in-person visit

Medical Information and Records:

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

Confidentiality:

- The laws that protect the confidentiality of your protected health information apply to telehealth, and no information or images from the telehealth interaction which identify you will be disclosed to other parties without your consent, except as permitted or required by law.

Rights:

- You may withdraw consent to a telehealth visits at any time without affecting your right to future care or treatment
- You have a right to inspect and/or access your protected health information transmitted during your telehealth visit as well as receive copies of it at a reasonable fee as set by state law
- You have a right to be informed of all parties who will be present at the receiving and originating site and have the right to exclude anyone from either site
- You have a right to object to videotaping or other recording of telehealth visit.

Financial Statement

Empower Physical Therapy & Aquatics Institute is operating under the assumption that your insurance company will reimburse telehealth visits performed by a physical and/or occupational therapist. If the services are payable by your insurer, we are by law required to collect your co-share (deductible, co-insurance or co-payment) at the time of service and will do so at the same rate as our face to face visits. If telehealth treatments for physical and/or occupational therapy turn out to be a non-covered service, the cost of the visit will not exceed the co-payment or co-insurance amount you would have paid for face to face services; these are also payable at the time of service.

Attestation:

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.

Patient's Signature:_____**Date**_____

Provider's Printed Name:_____**Date**_____

Signature:_____

Credit Card Authorization

At our medical practice, we strive to provide the highest quality care to our patients. In order to streamline our billing process and ensure that we can deliver the best care possible, we request that you provide us with a valid credit card to keep on file.

This credit card will only be used for charges that are not covered by your insurance policy. This may include co-payments, deductibles, non-covered services, or any outstanding balances.

Please be assured that we take your privacy and security seriously. Your credit card information will be kept confidential and will only be accessible to authorized personnel who require it for billing purposes. Our practice follows all HIPAA regulations to ensure that your information is protected.

By signing below, you authorize our practice to keep your credit card information on file and use it for any outstanding balances not covered by your insurance policy.

Thank you for choosing our practice for your healthcare needs. If you have any questions or concerns about this credit card authorization, please do not hesitate to ask our staff.

Patient Name: _____ Date: _____

Credit Card Information:

Credit Card Type: MasterCard Credit Card Number: _____

Expiration Date: _____	Security Code: _____

Signature: _____