Telehealth Informed Consent Form

Patient Name: _____ Date of Birth ___/___/___

Patient Address: _____

Purpose: The purpose of this form is to obtain your consent to participate in physical therapy treatments through telehealth.

1. Nature of Teleheath Consultation: During the telehealth consultaion:
    - Details of your medical history, examinations, imaging, and test results may be shared with other health care professionals through the use of interactive video, audio and telecommunication technology
    - A digital physcial examination may take place
    - Video, audio and/or photo recording of visits may be taken of you only for the treatment purposes.
    - A non-medical technician may be present during a call to assist with video transmission.
2. Medical Information and Records: All existing laws regarding your access to medical information and copies of you medical records apply to telehealth visits. Please note, telecommunications will, generally, not be recorded and stored. A written record of the visit will be created for medical records. Additionally, dissemination of any patient identifable images or information for this telehealth interaction to any other parties or entities shall not occur without your expressed consent.
3. Confidentiality: All reasonable and appropriate efforts have been made to eliminate any condifentiality risks associated with telehealth visit. Our telehealth platform Doxy.me is HIPAA compliant. There is no recording or sharing of the visit by any third party to ensure your privacy is maintained.
4. Rights: you may withhold or withdraw your consent to telehealth at anytime without affecting your right to future care or treatment
5. Limits: Telehealth visits can only take place as long as you are currently residing in the state of Iowa.

I agree to participate in telehealth care with JET Physical Therapy for the procudures and/or services listed above.

Signature: _____ Date ___/___/___

If signed by someone other than the patient, indicate the relationship: _____

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