Telehealth Patient Consent Form

Alliance Physical Therapy offers some physical therapy consultations via a telemedicine/telehealth platform. If you elect to receive our telehealth services, you must give informed consent and agree to the following:

1. Our physical therapy telemedicine/telehealth consultations are provided through a HIPAA compliant and secure platform, Doxy.me. By using this service, you agree to the terms of use and privacy policies of this telemedicine/telehealth

2. The benefits to using our telemedicine/telehealth services including but not limited to not having to take time to drive to and from appointments, minimizing time off work for appointments, being able to access services at more convenient times.

3. We strive to provide telehealth services at the same standard of care of an in-person visit. However, you should know that there may be some limitations to what we can do through a telehealth connection compared to a face-to-face visit. For example, we will not have the ability to observe your body/condition in a 3-dimensional view. If the limitations of a telemedicine/telehealth consultation will interfere with our ability to properly examine or treat you, we will let you know so you can schedule a face-to-face visit with us or another provider of your choice.

4. Some state laws or health plan policies may require an initial evaluation to be provided in-person before telemedicine/telehealth visits can be provided. We will let you know if any state laws require us to see you in the office on the evaluation, but you are responsible for figuring out if your health plan requires an in-person visit for the initial evaluation as a condition of payment for our services.

5. There are potential risks with the use of telehealth technology, including but not limited to: (1) interruption of the audio/video link, (2) disconnection of the audio/video link, (3) video that may not be clear enough to meet the needs of the consultation, and (4) potential of unauthorized access to the live or stored consultation. If any of these occur, the consultation may need to be stopped and/or rescheduled. Also, we are not responsible for these or other technology problems that we are not in control of.

6. Privacy and Confidentiality. The same state and federal laws that protect your privacy and the confidentiality of your medical records apply to our telemedicine/telehealth visits if the visit is for health care services. You acknowledge by signing below that you have been given an opportunity to review our Notice of Privacy Practices and had all your questions answered.

7. Some health plans may cover telemedicine/telehealth services if they are medically necessary. Some state laws require state-governed (fully insured) health plans to cover telemedicine/telehealth visits if the health plan would have covered the same interventions had they been provided in the office. However, there are frequently exceptions to these coverage laws and policies. That means your health plan may deny our claims for telemedicine/telehealth services. Therefore, by consenting to receive our services through a telemedicine/telehealth means, you agree to

personally pay for any services your health plan does not cover even if your Explanation of Benefits (EOB) from your health plan states you owe $0 for our services.

8. If we instruct you on any exercises, balance activities or other physical procedures during the telemedicine/telehealth session, you are responsible for determining whether you can safely perform the activity without risk of falling or otherwise injuring yourself. If you do not feel safe, you must tell us. If the exercise or activity requires the assistance of a family member or caregiver (collectively "Caregivers"), you are accepting the risk of the actions of your Caregivers. We are not responsible if you fall or get injured by the actions, errors or omissions of your Caregiver.

I, ______________________________________ [print name], have read, understand and agree to all the above terms for my telemedicine/telehealth consultation. Understanding the limitations and risks associated with a telemedicine/telehealth consultation as described above, I consent to the examination and/or treatment through Company's telemedicine/telehealth service.

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Patient's signature Date

____ _________________

Witness Date