Patient Name: _____Date of Birth: ___ /___/__ Medical Record #_____

Patient Location: _____Home Phone: _____

Informed Patient Consent Form Telehealth Services

Telehealth is the delivery of healthcare services using technology when the healthcare provider and patient are not in the same physical location. Providers may include primary care practitioners, specialists, and/or subspecialists.

Electronically transmitted information may be used for diagnosis, treatment, follow-up, and/or patient education, and may include any of the following:

• Medical records;

• Medical images;

• Interactive audio, video, and/or data communications; and/or

• Output data from medical devices, sound and video files.

Oasis Physical Therapy has interactive electronic systems used within its network. Security software and protocols are employed to protect the confidentiality of member information and imaging data. Safeguard measures include protecting against intentional or unintentional corruption.

Potential Patient Benefits:

1. Improving access to specialized medical care by enabling members to either remain within physician's office or electronically discuss with physician on duty any test results and any consults with a distant specialist at a remote location.

2. Obtaining the expertise of a distant specialist.

Potential Patient Risks: As with any medical procedure, there may be potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by physician on duty and a distant specialist.

2. Distant specialist may not be able to provide medical treatment using telehealth equipment nor provide for or arrange for any emergency care that may be required.

3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

4. Security protocols could fail, causing a breach of privacy of confidential medical information.

5. A lack of access to complete medical records may result in errors.

By signing this form, the Patient understands and agrees to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telehealth. Information obtained during a telehealth encounter, which identifies patient, should not be disclosed to any third party without patient's consent except for the purposes of treatment, payment, and healthcare operations.

2. Telehealth may involve electronic communication of patient confidential medical information to other medical providers who may be located in other areas, including out-of-state.

3. Patient understands that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the distant specialist.

4. Patient has the right to withhold or withdraw consent to the use of telehealth during the course of patient care at any time. Patient understands by withdrawing consent will not affect any future care or treatment, nor will it subject patient to the risk of loss or withdrawal of any health benefits to which the patient is entitled.

5. Patient has the right to inspect all information obtained and recorded during the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. Such inspection and copying of records shall be subject to physician on duty or distant specialist's office policies and procedures.

6. Patient may expect the anticipated benefits from the use of telehealth in members care, but that no results can be guaranteed. The patient's condition may not be cured or improved, and in some cases, may get worse.

7. Patient understands that the members condition may require a referral to a specialist for further evaluation and treatment.

8. A variety of alternative methods of medical care may be available to patient, and the patient may choose one or more of these at any time.

The patient has read and understand the information provided above regarding telehealth and all questions have been answered to patient's satisfaction.

The patient hereby gives their informed consent for the use of telehealth in their medical care.

I hereby consent to and authorize Oasis Physical Therapy to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for Patient): _____

If authorized signer, relationship to Patient: Witness: _____

Date: _____