Beth Shelly Physical Therapy

CONSENT FOR TELEHEALTH SERVICES

I, _____ (name of client) hereby consent to engaging in telehealth with Beth Shelly DPT at Beth Shelly Physical Therapy. I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, prescribing and help with decision making. Telehealth may include health care delivery, diagnosis, consultation, and therapeutic treatment. Telehealth will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

I understand that I have the following rights and responsibilities with respect to telehealth:
(1) I have the right to withhold or withdraw consent for telehealth at any time.

(2) It is ideal to complete an onsite, in-person screening by Beth Shelly PT during the first two or three physical therapy sessions. Beth Shelly will inform me if a referral for telehealth services is appropriate. Receiving telehealth services may be contraindicated with some conditions and diagnosis.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my clinician believes I would be better served by another form of intervention (e.g. face-to-face services) I will be deferred to an office visit.

(3) For a patient to receive telehealth services, she/he must be physically located in a state where the telehealth clinician is licensed (Illinois or Iowa). Telehealth service may not be provided in international jurisdictions. However during the COVID 19 state of emergency it may be possible to receive treatment if the is in another state.

(4) Privacy Act (see New patient information) apples to telehealth. The telehealth platform used by Beth Shelly Physical Therapy (Doxi.me) is HIPPA secure. It protects and encrypts all audio, video, and screen sharing data. It does not have access to my personal information and does not persistently store information that is transmitted. Although the telehealth system makes every effort to ensure the security of the telehealth transmission, I understand that there are potential security risks when personal information is transferred between a health care clinician, a patient and the telehealth system. I further understand that, Beth Shelly PT does not anticipate recording any telehealth sessions, there may be instances in which sessions may be recorded and pictures taken and stored. These recordings will become part of the medical record and protected under applicable federal and state law. Verbal permission from the patient will be necessary each time pictures are taken. I understand I may refuse to allow recording or pictures to be taken and stored.

During the COVID 19 emergency it may be necessary to use non encrypted forms for telehealth in compliance with physical distancing regulations. These forms include FaceTime, WhatsApp, and phone. I will discuss with my clinician which form of communication is best for me.

I also understand that I should only attend the telehealth sessions when I am in a private environment and in surroundings that ensure confidentiality with an atmosphere conducive to a therapeutic session.

(5) I understand that there are risks and consequences from telehealth, including, but not limited to, interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth visit if it is felt the video conferencing is not adequate for the situation.

I also understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my clinician, my condition may not improve, and in some cases may even get worse.

(6) I understand that I may benefit from telehealth services, but results cannot be guaranteed or assured.

(7) I understand I will be responsible for any co-payments or co-insurance that apply to my telehealth visit (see specific insurance coverage policy). There is no guarantee of payment from any insurance company.

By electronically signing this document I agree:
I have read and understand the information provided above. I have discussed it with my Clinician, and all of my questions have been answered to my satisfaction.

Signature of client _____ Date _____

Printed name of client _____