Informed Consent for Telehealth Services

Patient Name: _____ Date of Birth: _____

Medical Record #: _____
Location of patient : _____

Referring Provider: _____
Treating Provider : _____Location: _____
Treating Provider: _____Location: _____
Date Consent Discussed: _____

_____ (initial) I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Optimal Sports Physical Therapy, LLC, providing health care services to me via telehealth.
_____ (initial) I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, your insurance carrier will have access to your medical records for quality review/audit.
_____(initial) I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
_____ (initial) I may revoke my consent orally or in writing at any time by contacting Optimal Sports Physical Therapy, LLC at (406) 502-1782. As long as this consent is in force (has not been revoked) Optimal Sports Physical Therapy, LLC, may provide health care services to me via telemedicine without the need for me to sign another consent form.

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

_____
Printed Name of Patient (or person authorized to sign for patient):

_____ _____
Signature of Witness: Date:
_____ (initials) I have been offered a copy of this consent form