Madison Physical Therapy Telemedicine Consent Form

411 SE 10th St, STE 103, Madison, SD 57042 – Phone: (605) 556-0175 Fax: (605) 556-0162

I (name)_____ agree to receive this health care service, Physical Therapy, as a Telehealth service. I understand that the health care providers (PT/PTA) are located at a distant site during the time of appointment.

Telehealth service means that my visit with the physical therapists and/or assistants at the distant site will happen by using audiovisual equipment. This consent is valid for six months for follow-up telehealth services with the health care providers.

I also understand that:

I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
I may have to travel to see the physical therapists in-person if I decline the Telehealth service.
If I decline the Telehealth services, the other option/alternative available for me, including in-person services are e visits.
The same confidentiality protections that apply to my other medical care also apply to the Telehealth Service. I will have access to all medical information resulting from the Telehealth service as provided by law. The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent. I will be informed of all persons who will be present at all sites during my Telehealth service.
I may exclude anyone from any site during my Telehealth service.
I may see an appropriately trained staff member or employee in-person after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
I also understand that my insurance will be billed for this visit with a consulting health care provider, and that I may be billed for what my insurance does not cover, depending upon the provider. I understand that if I have any questions about my billing I will need to talk to my provider's office manager. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payor. I give permission for the Madison Physical Therapy office to provide limited information to the coordinator at this site for billing purposes.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months and will be renewed after _____.

Name: _____ DOB:_____

Address:_____

Signature:

_____ Today's Date: _____

Parent Name:

_____

Parent Signature (if minor): _____