Therapydia Informed Consent for Telemedicine Services

Patient Name: _____ Current Location:_____

Date of Birth : _____

Physical Therapist:_____ Current Location: _____

I understand that telemedicine 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. I hereby consent to Therapydia providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

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

_____

Date: If authorized signer, relationship to patient:

_____

I have been offered a copy of this consent form (patient's initials): _____