Integrative Manual Therapy & Wellness
Telemedicine/ TeleHealth Patient Consent Form

Patient Name: _____ **Date of Birth**: _____

1. **Purpose**: the purpose of this form is to obtain your consent to participate in a telemedicine/telehealth consultation in connection with your current or future physical therapy care (including evaluation if applicable, treatment, home program [consisting of neuromuscular re-education, therapeutic activities, therapeutic exercises, or self-mobilization & soft tissue techniques], education and advice).

2. **Nature of Telemedicine Consult:** During the telemedicine session:
    a. Details of your medical history, examinations, x-rays/images, and tests may be discussed with you (& perhaps with other health professionals) through the use of live two-way interactive video, audio, and telecommunication technology.
    b. A virtual physical examination of you may take place to the best of our abilities
    c. We may ask that video or photos of you be sent to us for assessment purposes.
    d. The information gathered may be used for diagnosis, therapy, follow-up and/or education.

3. **Medical Information and Records**: All existing laws regarding your access to medical information and copies of medical records apply to telemedicine consultation. Please note, not all telecommunications are recorded or stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to other entities shall not occur without your consent.

4. **Confidentiality**: All appropriate & reasonable efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all confidentiality protections under federal and Virginia State law and HIPPA privacy policy apply to information disclosed during telemedicine sessions.

5. **Rights**: You may withdraw consent to telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **Disputes**: You agree that any dispute arriving from the telemedicine consult will be resolved in Virginia, and that Virginia Law shall apply to all disputes.

7. **Risks, Consequences, and Benefits**: I have completed INTEGRATIVE'S New Patient Packet and have been advised of all the potential risks, consequences, and benefits of PT via telemedicine. Your health care practitioner has discussed with you the information provided above if need be. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

8. **Billing/Payments:** I understand that I may either (1) request to file these therapy services through my insurance via INTEGRATIVE's regular PT billing procedure (with special telehealth modifying codes if needed) as long as we participate with your insurance, or (2) pay the telehealth self-pay rates. I acknowledge that my insurance co-payments, cost-shares, and/or deductible still apply to telehealth sessions (and are due at the time of service) as per INTEGRATIVE's Financial Agreement which I have signed as part of my medical record.

I agree to participate in INTEGRATIVE's telemedicine sessions as described above:

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____
Signature:_____ Date: _____

INTEGRATIVE
MANUAL THERAPY & WELLNESS