Thrive Physical Therapy

9518 Roosevelt Way NE, Seattle, WA 98115
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Patient Name: _____ Date: _____

1. I understand that my health care provider and I wish to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from my practitioner and/or facility from the site from which I am presented. I understand the provider and facility cannot guarantee that this will be a covered benefit with their insurance and that by consenting to this form of treatment they will be financially responsible if their insurance denies.

8. I have had a direct conversation with my health provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

9. I understand the policy and procedure agreement is the same as for the onsite clinic agreement that I have signed.

10. I have the right to withdraw my consent for telemedicine at any time without it affecting my future care. Late cancelations and no-show fees still apply if cancelled <24 hours in advance.

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me, that I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____	_____
Patient's/parent/guardian signature	Date	Time	Expiration Date if applicable
_____	_____	_____	
Witness Signature	Date	Time	