Brostrom Physical Therapy
Spine and Extremity Institute of South Lyon, LLC

Telehealth Consent Form

Patient Name: _____ Date of Birth: ____/____/____

Introduction: In light of the COVID-19 situation and your possible corresponding preference to reduce community exposure, Brostrom PT is making available the use of telehealth visits, which is video communication whereby our physical therapists can provide evaluation and management services. During a telehealth visit, a PT can perform an evaluation and make recommendations, including but not limited to:

- What household activities to participate in or refrain from or, if necessary, how to modify household activities;
- What exercises to participate or refrain from;
    - If a home exercise program needs to be established or progressed, our PT can draft a comprehensive program that includes picture and/or video tutorials and guidelines on parameters (repetitions and sets, number of times per day/week).
- Whether ice and/or heat is recommended for your condition.

Criteria: In accordance with direction received from the Center for Medicare Services (CMS), telehealth visits are available to new and existing patients ***and*** if the following criteria are met:

1) If a physical visit is not condoned or sought considering the COVID-19 situation;
2) If you verbally request and consent to a telehealth visit; and
3) The telehealth visit is performed using a non-public-facing remote communication product such as Apple FaceTime, Whatsapp video chat, Zoom, or Skype.

Medical Information & Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth evaluation or consultation. Dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities will not occur without your consent.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth evaluation/consultation, and all existing confidentiality protections under federal and Michigan state law apply to the information disclosed during the telehealth evaluation/consultation.

Rights: You may withhold or withdraw consent to the telehealth evaluation/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. You consent to being photographed, recorded, or videotaped, and agree that such photographs, recordings, or videotapes will be stored by Brostrom PT for up to a period of 1 (one) year. In addition, you may ask to verify the identity or licensure of any Brostrom PT staff during the telehealth visit.

Disputes: You agree that any dispute arriving from the telehealth evaluation or consult will be resolved in Michigan, and Michigan law shall apply to all disputes.

Insurance Cost-Sharing: As of April 15, 2020, physical therapists are not listed in CMS and many other private payor's lists of health care providers that can be reimbursed for telehealth services. As a result, you understand that your insurance will **not** be billed for services rendered via the telehealth evaluation/consultation and you will be responsible for the non-refundable, private pay rate of $50.00 for each telehealth evaluation/consultation.

Risks, Consequences, & Benefits: Electronic systems used will incorporate software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. As with any medical procedure, however, there are potential risks associated with the use of telehealth visits. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physical therapist;
- Deficient or failures of technology may result in delays of medical evaluation and treatment;

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in judgment errors.

You are also made aware that the use of telehealth evaluation/consultations present limitations when compared to a face-to-face encounter, such as the inability to perform hands-on examination, assessment, and treatment.

By signing this form, you understand the following:

1. The laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to researchers or other entities without your consent.
2. You have the right to withhold or withdraw your consent to the use of telehealth in the course of your care at any time, without affecting your right to future care or treatment.
3. You have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to you, and that you may choose one or more of these at any time. Brostrom PT has explained the alternatives to my satisfaction.
5. Telehealth may involve electronic communication of your personal medical information to other medical practitioners who may be located in other areas.
6. It is your duty to inform Brostrom PT of electronic interactions regarding your care that you may have with other healthcare providers.
7. You may expect the anticipated benefits from the use of telehealth in your care, but that no results can be guaranteed or assured.

You have been advised of all the potential risks, consequences, and benefits of telehealth visits, and agree to hold Brostrom PT harmless for medical or other information lost because of technology failures. Your health care practitioner has discussed with you the information and benefits of telehealth visits. You have had the opportunity to ask questions about the information presented on this form and the telehealth evaluation/consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in telehealth evaluation/consultations relating to a physical therapy plan of care.

_____ ____/____/ 2020

Signature Date