Consent for Telehealth Services

Patient Name: _____ Date of Birth: _____

Primary PT/OT: _____ Clinic Location: _____

Telehealth is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. During the COVID-19 pandemic, the Excel Physical Therapy team will utilize telehealth services to deliver care to patients that request this mode of treatment due to the risks of the infection. Our team will utilize FaceTime or doxy.me audiovisual platform to communicate with patients.

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information apply to telemedicine. Therapists will document your telehealth encounter in our secure electronic medical record systems.
2. I have the right to withhold or withdraw my consent to the use of telehealth in writing at any time during the course of my care. I understand that my withdrawal of consent will not affect any future care or treatment at Excel Physical Therapy.
3. My insurance company will be billed for any telehealth services I receive based on the time spent with my therapist and the guidelines established by my insurance company. I understand I am responsible for any applicable deductible, coinsurance and copay my insurance company indicates is due for my treatment.
4. In the event my insurance company does not cover telehealth services for physical/occupational therapy, I understand that I will be responsible for the telehealth services I receive according to the fee schedule outlined below:
    - 30 minute encounter: $40.00
    - 60 minute encounter: $75.00
    - Initial Evaluation (60 minutes): $90.00
5. Telehealth services will not include the hands-on manual therapy provided through in-office treatment. My therapist will provide patient education, exercise program design, modification and progression through the use of telehealth. I understand that improvement in my condition is not guaranteed and my symptoms could worsen during the use of telehealth.
6. As a legal guardian of the above named minor patient (< 18 years old), I agree to be present at the location during the delivery of telehealth services.

I have read and understand the information provided above regarding telehealth services. I hereby give my informed consent for the use of telehealth for physical/occupational therapy rendered by Excel Physical Therapy's licensed providers.

Patient/Guardian Signature: _____ Date: _____