COASTAL PHYSIOTHERAPY CLINIC

Patient Name: _____ Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to conduct such a consultation, and that it 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, and technical difficulties. I understand that my health care 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. I also understand that correspondence about my condition may be shared with other health practitioners and my insurer including my referring doctor to facilitate communication, but I will be informed as to which practitioners. **Please write your initials here ……..**

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 normal exam involving physical tests may be conducted with alternative methods at the direction of the consulting health care provider.

6. I agree that

 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 consultations (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