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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

The purpose of this form is to obtain your consent to participate in a telehealth consultation with the following Physical Therapist: Dr. Gregory LeMoine, P.T. D.P.T.

1) **Purpose and Benefits.** The purpose of this project is to use telehealth to enable patients living in rural and/or underserved areas to get physical therapy care by physical therapists without the inconvenience and expense of traveling to a city.

2) **Nature of Telehealth Consultation:** During the telehealth consultation:

- a) Details of you and/or your child's health history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
- b) Physical examination of you or your child may take place.
- c) Nonhealth technical personnel may be present in the telehealth studio to aid in video transmission.
- d) Video, audio, and/or digital photo may be recorded during the telehealth consultation visit.

3) **Health Information and Records.** All existing laws regarding your access to health information and copies of your medical health records apply to this telehealth consultation. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation. All existing confidentiality protections under federal and Maryland State law apply to information disclosed during this telehealth consultation.

5) **Risks and Consequences.** The telehealth consultation will be similar to a routine physical therapy office visit, except interactive video technology will allow you to communicate with a physical therapist at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physical therapist contact. Following the telehealth consultation, your physical therapist may recommend a visit to a doctor or hospital in Baltimore for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the physical therapist in person if you travel to his or her location.

7) **Financial Agreement.** This telehealth consultation will be paid for by insured participate using patient health insurance. You and/or your insurance company will be billed for this visit.

I have been advised of all the potential risks, consequences and benefits of telehealth. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature: _____ Date: _____
Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient: _____

Witness: _____ Date: _____