INTEGRATED PHYSICAL THERAPY, LLC
Phone 1-608-658-5352
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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION/TREATMENT

The purpose of this form is to obtain your consent to participate in a telehealth consultation or treatment with Integrated Physical Therapy, LLC.

1) **Purpose and Benefits**: The purpose is to enable patients to utilized telehealth for a component of their physical therapy plan of care and treatment without the inconvenience of traveling to the physical location.
2) **Nature of Telehealth Consultation/Treatment**: During the telehealth consultation:
    a. Details of your past medical history, current history
    b. Examination by demonstration of ROM, functional strength, and some special testing
3) **Medical Information and Records**. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation/treatment.
4) **Confidentiality**. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation/treatment. All existing confidentiality protections under federal and Wisconsin State law apply to information disclosed during this telehealth consultation/treatment. I agree that the therapist may leave a message via voicemail.
5) **Risks and Consequences**. The telehealth consultation/treatment will be similar to a routine office visit, except interactive video technology will allow you to communicate with a therapist at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to healthcare and education services is a new technology and may not be equivalent to direct patient to therapist contact. Following the telehealth consultation/treatment, your therapist may recommend a visit to our office for in office treatment.
6) **Rights**. You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right of future care or treatment. You have the option to consult with the therapist in person if you travel to their location.
7) **Financial Agreement**. This telehealth visit will be billed as a private pay visit in which payment is required before the start of the visit. If your insurance company will cover such visit, you may choose that your insurance be billed for the visit.
8) **Residence**: I verify at the time of consultation/treatment that I am a resident of the State of Wisconsin.
9) **Communication of Forms:** Forms should be faxed to 1-888-965-4018, if unable to fax, you may choose to email forms or communicate via info@integratedpt.org although you do consent that this is not a guaranteed form of secure communication.
10) I have initiated telehealth communication with Integrated Physical Therapy.

I have been advised of all the potential risks, consequences and benefits of telemedicine. 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_____