TELEHEALTH PATIENT CONSENT/REFUSAL FORM

Patient Name:

Patient Address:

Patient Date of Birth:

Purpose of Release: The purpose of this form is to obtain your consent to participate in a Telehealth Consultation/Treatment in connection with the following procedures(s) and/or services(s):

1. **Nature of Telehealth Consult: During the telehealth consultation:**
    a. Details of your medical history, examinations, x-rays, and tests will be discussed with healthcare professionals through the use of interactive video, audio and telecommunication technology.
    b. A digital physical examination may take place.
    c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
    d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or services(s) for treatment purposes only.
2. **Medical Information & Records:** All existing laws regarding your success to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent.
3. **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth consultations, and all existing confidentiality protections under state and federal law apply to information disclosed during this telehealth consultation.
4. **Rights:** You may withhold or withdraw your consent to the telehealth consultation at any time without affecting your right to future care of treatment.
5. **Disputes:**_____
6. **Risks, Consequences & Benefits:** You have been advised of all the potential risks, consequences and benefits of telehealth. Your healthcare provider has discussed with you the information provided above.
7. **Insurance Benefits:**
    a. Coverage/Non-Coverage:
    b. Patient Responsibility:
8. **Refusal:** Accept
    a. Please indicate whether you accept telehealth services or refuse telehealth services by stating ACCEPT OR REFUSE.

I agree to participate in telehealth care with Northwest Rehabilitation Associates, Inc. for the procedure(s) and/or service(s) listed above. I further understand that my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payments of telehealth charges incurred.

_____ _____

PRINT PATIENT'S NAME OR NAME OF PATIENT'S LEGAL REPRESENTATIVE PATIENT'S DATE OF BIRTH

_____ _ _____

SIGNATURE OF PATIENT OR PATIENT'S LEGAL RESPRESENTATIVE DATE