



KinesioWorks Physical Therapy, P.C.
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INFORMED CONSENT FOR PHYSICAL THERAPY TELEPRACTICE

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Tel/Mobile Phone No: _____ Email Address: _____

Introduction

Telepractice or telehealth involves the use of electronic communications that include messaging, email, phone call, and secured real-time video conferencing to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or physical therapists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to physical therapy care by enabling a patient to remain in home residence or a secure remote location while the physical therapist provides assessment, physical therapy treatment, and consultation from a distant site.
- More efficient physical therapy evaluation and management.

Possible Risks:

- As with any physical therapy procedure, there are potential risks associated with the use of telepractice. These risks include, but may not be limited to:
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate clinical decision making by the physical therapist(s);
- Delays in physical therapy evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result judgment errors;

Patient's Initials: _____

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepractice, and that no information obtained in the use of telepractice which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepractice in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that telepractice may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
4. I understand that it is my duty to inform my physical therapist of electronic interactions regarding my care that I may have with other healthcare providers.
5. I understand that I may expect the anticipated benefits from the use of telepractice in my care, but that no results can be guaranteed or assured.
6. I understand that for my own personal privacy and the privacy of the physical therapist staff, I shall not record, share, post or otherwise disseminate audio or video of physical therapy telepractice sessions.
7. I understand that I am responsible for obtaining, securing and/or purchasing the telecommunications devices to be used for physical therapy telepractice. The said telecommunications devices may include, but not limited to, desktop and laptop computers, tablets, home telephone units and smartphones.
8. I understand I am responsible for internet and phone connection subscription fees and other related fees.
9. I fully understand and acknowledge that the physical therapy telepractice activities in which I will engage as part of the physical therapy care may have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities;
10. I understand that my participation in these physical therapy telepractice activities, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of KinesioWorks Physical Therapy, PC or by any other person.
11. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of KinesioWorks Physical Therapy, PC.
12. I understand and have read the above, and by signing the consent below that I, _____, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, indemnify, and relieve KinesioWorks Physical Therapy PC and their representatives, employees, and assigns from any liability and all claims, actions or losses for personal bodily injury, property damage, wrongful death caused by negligence or any other cause, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities.

Patient Consent to the Use of Physical Therapy Telepractice

I have read and understand the information provided above regarding telepractice and have discussed it with my physical therapist, and all of my questions have been answered to my satisfaction.

- I hereby give my informed consent for the use of telepractice in my physical therapy care.
- I do not consent to physical therapy telepractice
- I revoke my consent to physical therapy telepractice

Patient Signature: _____ Date: _____