

Arctic Physical Therapy Services (APTS) Informed Consent for Telehealth Services

Telehealth services involve the use of electronic communication to facilitate healthcare services (in this case, physical therapy). Electronic communication involves live two-way audio and video and may be supplemented with communication via phone and/or email. It may be used to initiate or continue existing physical therapy care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

-Access to physical therapist and physical therapist assistant expertise and care when in-person access is not feasible.

Possible risks:

-Information transmitted may not be sufficient (poor resolution of images or poor sound quality) to allow for decision making or technology failure could delay evaluation or treatment.
-Security protocols could fail causing a breach of privacy of personal medical information.
-Others within your vicinity may overhear or view your telehealth session if you are not in a private area.

Therapist responsibilities:

1. Provide the best possible physical therapy care possible within the electronic environment.
2. Guide patients and/or caregivers toward independent management with a home program.

Patient Responsibilities

1. Have access to appropriate technology for participation including internet connection and video and audio capabilities as well as an environment that will allow for clear visualization and communication.
2. Facilitate the level of privacy you desire during sessions. For example, use a private room in your home if there are others present you do not wish to view or hear your session.
3. Maintain proper decorum as if your visit were occurring in a public space.
4. Be as prepared as possible for your visit with equipment readiness as guided by your therapist (both technology and any exercise equipment your therapist recommends).
5. Take an active role in your plan of care by collaborating with your therapist and participating in your home program.
6. Be available at the time designated by your therapist or APTS.

Please initial after reading this page_____

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 telemedicine and that no information obtained in the use of telemedicine which identifies me will be shared with entities other than my referring physician.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect written documentation recorded during my telehealth sessions (audio/video data of sessions are not recorded) and receive copies for a reasonable fee as I would with in-person care.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Technology Failure Contingency

Pending the failure of technology before or within a session, APTS will attempt to reach you via your provided telephone number and discuss a contingency plan. Exercises can be emailed to you via an online platform as available which can include videos and written instructions for exercise performance.

Patient Consent To The Use Of Telehealth Services with APTS

I have read and understand the information provided above regarding telehealth services, discussed with APTS staff and all of my questions have been answered to my satisfaction. I hereby give my informed consent to the use of telehealth services in my physical therapy care with Arctic Physical Therapy Services, Inc.

Signature of Patient

X _____ Date: _____

Signature of Parent or Guardian

X _____ Date: _____

Please email the signed form to arcticpt@protonmail.com