



INFORMED CONSENT FOR TELEMEDICINE SERVICES

Complete this form to consent to telemedicine visit(s)

- ❖ I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- ❖ I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and/or hear my voice. I will be able to hear and/or see the healthcare provider.
- ❖ I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- ❖ I understand that I will be responsible for any payments that apply to my telemedicine visit, as it is currently not a covered benefit for physical therapy in the state of Colorado.
- ❖ I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- ❖ I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Patient/Client Signature

Date Signed

Check Box to the left if signed electronically.