Michiana Spine, Sport, and Occupational Rehab

Telemedicine Disclosure and Consent

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Treating Physical Therapist: _____

Clinic Location: ☐Mishawaka, IN ; ☐Niles, MI; ☐ St. Joseph, MI; ☐ Kalamazoo, MI

Telemedicine Disclosure and Consent:

1. I understand that my health care provider wishes me to engage in a telemedicine/virtual visit.
2. My health care provider has explained to me how the video conferencing technology will be used. The visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine/virtual visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the visit at any time.
5. I have had the alternatives to a telemedicine visit explained to me.
6. In an emergent situation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand with each session I must show a photo ID, as will my clinician, to establish identity.

By signing below I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedures.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____ Date:_____