

For More Information

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Informed Consent for Telehealth Visit

Patient Name: _____ Date: _____

This Authorization is to provide my informed consent for the use of telehealth intervention with my therapist at LifeCare Therapy Services.

What is Telehealth?

Telehealth is a way to talk to your provider by phone, computer or tablet and uses video so you and your provider can see one another. By using telehealth, you do not have to go to a clinic to see your therapist or have anyone come into your home for therapy services. Telehealth, implemented correctly, has equal outcomes to face to face interventions.

Can Telehealth be Bad for Me?

You and the therapist won't be in the same room so it may feel different. If telehealth does not feel right for you or if the therapist recommends that the visits be face-to-face, then the visit may be changed to a face to face visit. Also know that technical problems may interrupt or stop your visit.

Will My Visit Be Private?

LifeCare will not record your therapy visits and your therapist will inform you if someone else is present near their office that could possibly see or hear you. Our telehealth services will use technology that is intended to protect your privacy but there is always a small chance that someone who is not authorized could use technology to hear or see your visit.

What if I Try Telehealth and Do Not Like It?

You can stop using telehealth at any time, even during a visit. Please let your therapist or LifeCare Team know that you would like to schedule face to face sessions.

How Much Does Telehealth Cost?

Telehealth charges are the same as face to face therapy services and LifeCare will bill your insurance company for you.

Authorization for Telehealth Services

With my signature below, I am acknowledging that I understand the benefits and potential risks of providing tele-therapy services and that my questions have been answered in a language that I understand. Specifically, I acknowledge that:

- I understand that the telehealth visit may not be the same as a direct face to face visit and that the program and activities may be modified to ensure my safety.
- 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 telehealth visit at any time.
- I am aware of my alternative options including face to face visits and I am electing to receive teletherapy services as a replacement or concurrent with my face-to-face visits.

This Informed Consent was ____ Read or ____ Delivered Face to Face On _____ [date] by

_____.

Patient Name (Print)

Patient Signature [if delivered]

Date

Responsible Party [If Other Than Patient] Name

Signature

Date