Bolanos | Associates
Comprehensive Therapy Solutions

Consent for Telerehabilitation Services

PATIENT NAME: _____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	Member # or Claim#: _____
THERAPIST NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

Introduction:

Telerehabilitation is the delivery of therapy services when the healthcare provider and patient are not in the same physical location through the use of technology. Electronically-transmitted information may be used for therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records.
- Interactive audio, video, and/or data communications.
- Output data from medical devices and sound and video files.

The interactive 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.

Purpose:

1. To provide telerehabilitation treatments services to patients. Telerehabilitation refers to the delivery of rehabilitation services via information and communication technologies. Clinically encompasses a range of rehabilitation services that include assessment, monitoring, prevention, intervention, supervision, education, consultation, counseling and observing patients' movements and note any aberrant movements, pain, or compensatory strategies. Check movements of both sides and also functional movement patterns following the physical and/or occupational therapist video simultaneously
2. Customize the treatment and instructional programs to meet patient's needs during the COVID-19 pandemic.

Bolanos | Associates
Comprehensive Therapy Solutions

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telerehabilitation. No information obtained during a telerehabilitation encounter which identifies me will be disclosed to researchers or other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telerehabilitation during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telerehabilitation interaction, and may receive copies of such records.
4. telerehabilitation may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
5. Refer back to MD or other practitioners as needed
6. I may expect the anticipated benefits from the use of telerehabilitation in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases
7. I understand that if I do not cancel my appointment within 24 hours, I will incur a $40.00 cancellation fee.

Patient Consent to The Use of Telerehabilitation

I have read and understand the information provided above regarding telerehabilitation, I have discussed it with my physician or such assistants, case managers or adjusters, as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telerehabilitation in my medical care.

I hereby consent to and authorize **Bolanos *Associates, LLC.*** to use telerehabilitation in the course of my physical or occupational therapy evaluation and treatment.

Signature of Patient (or person authorized to sign for Patient): *Date:* _____

_____

If authorized signer, relationship to Patient: *Date:* _____

_____

I have been offered a copy of this consent form (patient's initials) _____