HEALING MOTION
PHYSICAL THERAPY

Telehealth Physical Therapy Consent

If you would like to receive your Physical Therapy care via Telehealth with our HIPAA compliant, secure video communication software, please consent to doing so below and acknowledge your email security. If you so choose, you have the right to decline Telehealth Physical Therapy in the future by letting us know verbally and in writing. Please initial the following:

_____ I would like to receive all or at least some of my physical therapy care via telehealth.

_____ The email you have provided us with is NOT shared and only YOU have access to it/know the password to it (required by HIPAA).

_____ OPTIONAL (you don't have to initial) I would like my Telehealth PT treatment session(s) recorded. I reserve the right to request any session to be recorded or not.

Emergency Contact Information for Telehealth Sessions

Name:_____ Relationship to Patient: _____

Phone:_____

_____ _____

Patient or Authorized Representative Signature Date

_____

Patient or Authorized Representative Name (Print)