



## Telehealth 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).

### Emergency Contact Information for Telehealth Sessions

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Patient or Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Authorized Representative Name (Print)