Beyond Basics Physical Therapy, PLLC
110 East 42nd Street Suit 1504 NY, NY 10017
Phone (212) 354-2622 // Fax (212) 354-2752

INFORMED CONSENT - TELEHEALTH ADDENDUM

BEYOND BASICS PHYSICAL THERAPY provides a remote telehealth platform for all patients and clients under the practice care. This service is provided in order to ensure a seamless patient vs provider experience and currently uses third party applications to deliver this service. A list of these applications and their individual privacy policies can be found at: https://doxy.me/privacy-policy and https://doxy.me/terms-of-service

DEFINITION OF TELEHEALTH SERVICES

Telehealth involves the use of electronic communication including interactive audio, video, and/or data communication to enable clinicians, healthcare providers, and specialists to consult, diagnose, treat, educate, and deliver counseling and other healthcare services from a distant location.

BENEFITS & RISKS OF TELEHEALTH

Participation in telehealth services has both benefits and risks. A primary benefit of telehealth services is improved access to services by enabling a client to remain in his/her home or work. This can make treatment more comfortable and convenient, reduce travel, reduce need for childcare, and reduce a client's time from work or school. Similarly, telehealth makes services more accessible for those who struggle to leave their homes or who reside in rural areas where there is a health services provider shortage. As with any therapy service, there are potential risks associated with the use of telehealth. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Still, failures or deficiencies of equipment can result in delay of evaluation and treatment, and in rare cases, security protocols could fail, causing a breach of privacy of personal medical information.

CONFIDENTIALITY

The laws that protect privacy and the confidentiality of medical information for in-person therapy also apply to telehealth. Any information disclosed by the client during the course of therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence that the client may make towards a reasonably identifiable person. The client also understands that if he/she is in such mental or emotional condition to be a danger to self or others, the therapist has the right to break confidentiality to prevent the threatened danger. In addition, the client is solely responsible for the confidentiality of his/her own environment during a telehealth appointment.

COOPERATION WITH TREATMENT

I understand that during a telehealth session no hands on or manual treatment will be done. I understanding that during my participation in telehealth I will be responsible to report honestly about the any symptoms such as pain, fatigue, shortness of breath, or any abnormal occurrence. I am responsible for following the specific directions given to me during my telehealth session, and am responsible for requesting any clarifications needed. I understand that it is my complete right to stop any activity at any time.

CONSENT

I understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons.

I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of physical therapy services, such as in-person treatment, my clinician may request that I visit him/her in person to further evaluate my condition or be referred to a therapist in my geographic area that can provide such services.

I understand that the clinician will be at a different location from me. I understand that the clinician is licensed in the state of **NEW YORK STATE**, and therefore, practices under the laws of **NEW YORK STATE.**

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I hereby request and consent to telehealth services.

Patient Name: _____(please print) Date:_____

Patient Signature:_____

Signature of Parent or Guardian (if applicable):_____

Relation to minor and contact number:_____