UNIVERSITY OF GEORGIA
University Health Center
Student Affairs

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Informed Consent for Physical Therapy Telehealth Services

(Telephone Consultation and/or Online Audio/Video Consultation)

Patient Name: _____
UGA ID #: _____
Date of Birth: _____

Physical therapy care provided via telehealth is the utilization of technology by licensed physical therapy providers to provide physical therapy services including evaluation and treatment to patients located in remote locations. Telehealth services include telephone consultation and/or online audio/video consultation. The University Health Center utilizes Zoom online audio/video service through encrypted, private meetings between the physical therapist and patient to protect patient privacy. This online video service meets current regulations for HIPAA compliance. I understand that the evaluation and treatment of current medical condition(s) using a telephone consultation and/or synchronous audio/video consultation is under the Physical Therapy scope of practice similar to a clinic visit and will be carried out by a licensed practitioner.

Potential benefits: Benefits of telehealth include increased accessibility to physical therapy services from remote locations. As a result of this session I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience an increase in strength, awareness, flexibility, and endurance in my movements. I should gain a greater knowledge about actively maintaining my health and the resources available to me.

Potential risks: I may experience an increase in my current symptoms, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation.

Alternatives: If I do not wish to participate in this telehealth session, I will discuss the alternatives with my physical therapist.

- ☐ I understand that the Telehealth sessions differ from direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. This hands-off session(s) will consist of detailed discussion regarding my condition and may include a visual assessment of my movement patterns, balance, and range of motion. I agree to the Therapist's plan of care which may be modified for telehealth.

- ☐ I understand that I will be given a home exercise program and recommendations to allow me to progress towards my goals.

- ☐ I understand that during the course of my telehealth services, my healthcare provider may determine that telehealth services are not the most appropriate means for my physical therapy care, at which point the healthcare provider will then discuss with me the next appropriate action for my care.

- ☐ I understand that it is my responsibility to ensure that I am in a private space during my telehealth session in order to maintain the privacy of my health information. I understand the Physical Therapist will also conduct the session in a space that is conducive for keeping health information private and maintain professional guidelines.

- ☐ In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the telehealth connection.

- ☐ I understand that any physical therapy telehealth services provided are billable and will be filed with my health insurance company (if applicable).

- ☐ I have been provided the University Health Center Physical Therapy Clinic's policies regarding cancellations, insurance, expectations.

- ☐ I agree to participate in all Physical Therapy telehealth services including telephone consultations and/or online video consultations through HIPAA compliant Zoom platform.

- ☐ Please check to indicate that you would like to initiate a telehealth visit.

By signing this form, I agree that I have read this form, agree to and understand its contents including risks and benefits of telehealth and consent to physical therapy care via telehealth.

*If you have questions or concerns about the consent and would like to speak with the Physical Therapy Department prior to giving consent, please contact the PT Dept at 706-542-1259 prior to completion.

Patient Name

Signature Date/Time