Mann Therapies, LLC

Mann Method
PT and Fitness, PLLC

13825 W. 85th Drive, Suite 200
Arvada, CO 80005

Informed Consent for Telemedicine Services

Patient Information ("Patient")		
LAST NAME	FIRST NAME	MIDDLE INITIAL
LOCATION OF PATIENT		PHONE NUMBER
PROVIDER NAME:	PATIENT DATE OF BIRTH (mm/dd/yyyy)	

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.

Providers may include primary care practitioners, specialists like PTs and OTs, and/or sub specialists.

The information may be use for diagnosis, therapy, follow-up, and/or education and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Our HIPAA compliant Zoom Healthcare system incorporates network and software security protocols to protect the confidentiality of patient identification and imaging data and includes measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the provider provides physical or occupation therapy services
- More efficient medical evaluation and management

POSSIBLE RISKS: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

Please initial after reading this: _____

By signing this **Informed Consent for Telemedicine Services, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ***Mann Method PT™ & Fitness, PLLC and Mann Therapies, LLC*** to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient: _____ Date: _____

Signature of Legal Guardian/Personal Representative (if required): _____

Print name: _____

Legal Guardian/Personal Representative's authority to act on behalf of Patient: _____

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