Rehabilitation Associates,Inc.

Telehealth & Remote Therapeutic Monitoring (RTM) Consent Form

1. I understand that telehealth and RTM is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site other than the provider; and hereby consent to Rehabilitation Associates, Inc. providing health care services to me via telehealth or remote monitoring.
2. I understand that there are potential risks to using this technology, including interruptions, and I have been made aware that that my health care provider or I can discontinue the telehealth visit or remote monitoring if it is felt that the videoconferencing connections or remote communication are not adequate for the situation. I understand that I may be required to go to the location of the consulting specialist if I felt that the information obtained via telehealth was not sufficient
3. I understand that billing will occur under the facility fee of Rehabilitation Associates, Inc. and that I am responsible for any copayments or coinsurances that apply to my telehealth or RTM visit.
4. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks and benefits and any practical alternatives have been discussed with me in a language in which I understand.
5. I give my consent to be treated by Rehabilitation Associates, Inc. (telehealth & RTM provider). I also understand that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality.
6. I give Rehabilitation Associates, Inc. permission to send me emails that have the provider name and business name. **Email Address:** _____

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

If not client, relationship to client Witness Signature