Rehabilitation Associates Communication Consent From

Name: Date of Birth:

Telehealth & Remote Therapeutic Monitoring (RTM):

1. I understand that telehealth and RTM are digital technologies used by health care providers to improve communication and patient experience, and extend the ability to assess and treat target skills across settings. These services will be provided to you while located at a different site other than the provider. I hereby consent to Rehabilitation Associates, Inc. providing health care services to me via telehealth and/or remote monitoring.

2. I understand there are potential benefits (including improved access, consistency of care, and improved ability to assess and manage target skills and barriers across environments) and risks (including technical difficulties and security of personal health data) to using digital technology. I am aware that my health care provider or I can discontinue a telehealth visit or remote monitoring if not adequate for the situation. I understand that I may be required to go to the location of the consulting specialist if information obtained via telehealth/RTM is not sufficient.

3. I understand that I need to be in the state of Connecticut for telehealth services to take place and that I will need to confirm my specific location with my provider for safety purposes.

4. 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.

5. I will have a direct conversation with my therapist and/or Rehabilitation Associates staff member prior to initiating telehealth/RTM in order to make sure this is the right platform for my care, all alternatives have been considered, and that all of my questions regarding individual benefits and risks have been answered in a language that I understand.

6. I also understand that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality.

Email & Short Message Service (SMS) Messaging/Text Communication:

1. I consent to sending and receiving Emails and SMS (Short Message Service) messaging with Rehabilitation Associates.

2. I will use my/my child's first name only, be short/concise and to the point, be respectful with language, and limit context to only my/my child's program/progress/home exercises, when emailing my/my child's provider. I will not use SMS text/email for ANY cancel or change of appointments.

Appointment Reminders: Offered either by email or text, please choose one option below. :

___ Email: _____

___ Text: phone number: _____ Carrier: _____

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.
- That I consent to receiving communication via telehealth, RTM, email, and SMS text from Rehabilitation Associates.

I would like to opt out of: ☐ Email ☐ SMS Messaging/texting

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

If not client, relationship to client Witness Signature