**Informed Consent for Telehealth Visit**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residency of Patient**

Location of Patient (on this date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residency/Licensure of Clinician**

Location of Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State(s) of Licensure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Technology Platform Utilized:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Telehealth Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telehealth is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care and patient health-related education. Your care extended through telehealth may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

* Your health records
* X-ray or other diagnostic images
* Live two-way audio and video through a HIPAA compliant technology
* Output data from remote monitoring devices, and/or sound and video files pertinent to your clinical care

The Practice Name’s audio/video technology systems used will incorporate network and software security protocols to protect the confidentiality of your identification and imaging data and will include good faith measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption or access.

**Financial Responsibility**

I understand I assume full financial responsibility for the services provided through this telehealth visit.

**Privacy and Security**

I understand HIPAA regulations apply in telehealth. The technology platform used is encrypted and meets HIPAA security requirements. I understand it is important for me to be in a private location to do my part in keeping my health information protected during this telehealth visit.

**Patient Diagnosis and proposed treatment:** I have received my initial examination and the doctor explained to me the specific diagnosis that relates to my condition, and the proposed treatment options including but not limited to services that can be performed through telehealth procedures to include but are not limited to functional therapy type procedures including therapeutic exercises and functional activities. The benefits I may expect from my telehealth visit includes the enabling access to me from a remote site (such as my home) to receive necessary clinical care for my condition. It also enables my doctor to obtain test results and consult with other healthcare practitioners at distant/other sites, providing a more efficient medical and management of my condition.

Based on this, I give my permission to proceed with a telehealth visit and have the appropriate diagnostic tests, procedures, and a treatment plan for my condition(s). I understand that the treatment I receive at this clinic through telehealth is from a licensed Doctor of Chiropractic.  Chiropractic scope of practice includes a wide range of services, but if the clinician determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

**Known Risk factors:**

I understand that there are potential risks associated with the use of telehealth. 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 physician and consultant(s);
* Delays in evaluation and treatment could occur due to deficiencies or failures of the technology or internet connectivity;
* In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
* In rare cases, a lack of access to complete health records may result in clinical judgment errors;
* In rare cases, patients who withhold key past medical history or provide incomplete medical history may receive care that is not relevant or contraindicated, thereby putting the patient at risk for an adverse reaction to the treatment rendered
* Failure to follow the instructions and recommendations of the remote clinician could result in an adverse reaction to the treatment rendered.

I have been informed on known risks associated with the proposed treatment. I understand that like most health care procedures, functional therapy procedures carry with it some risks. Unlike many such procedures, the serious risks associated with the functional therapy procedures are extremely rare.

**The following are the potential risks:**

* **Temporary soreness or increased symptoms or pain** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
* **Dizziness, nausea, flushing** These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
* **Fractures** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
* **Disc herniation or prolapse** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
* **Other risks** include rare burns from physiotherapy devices that produce heat.
* **Bruising** some procedures may result in temporary soreness or bruising.

**Alternatives to telehealth chiropractic healthcare services:** I have been informed that I have the right to review and seek alternative health care treatment options for my condition. Those options discussed through a shared decision-making process include: Medicines, Physical Therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. I understand that these services can be performed in face to face settings as alternative to telehealth chiropractic care or if chosen, or depending on my specific case, in conjunction with the chiropractic care treatment plan designated for me in this clinic face to face.

**Risk of Refusing diagnostic and/or treatment procedures:** I have been properly informed of the known risks that of not receiving any treatment procedures and those risks may include a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

● **Patient Please Review ● Print & Sign Name** ●

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

By signing this form, I understand the following:

* I understand that the laws that protect privacy and the confidentiality of my health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent.
* I do consent to allow my doctor to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits. Such recordings are considered a part of my health record.
* I understand that I have the right to withhold or withdraw my consent to the use of telehealth and/or recordings in the course of my care at any time, without affecting my right to future care or treatment. I understand that this authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.
* I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and I may receive copies of this information according to the provisions provided under HIPAA.
* I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My doctor has explained the alternatives to my satisfaction.
* I understand that telehealth may involve electronic communication of my personal health information to other health care providers who may be located in other areas, including out of state.
* I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
* 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.

***I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely. I hereby give my verbal consent to use telehealth in the course of my diagnosis and treatment and to record the encounter in my personal health record.***

**Patient’s Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Guardian/Representative (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**(****Patient Guardian/Representative Signature) (Date) (Translator | Interpreter Signature) (Date)**

**Clinician Only**

Based on my personal observation, the patient’s history and physical exam, I conclude that throughout the informed consent process the patient was:

□ Of legal age □ Appears unimpaired □ Consent given through Guardian/Patient Representative

□ Oriented x3 □ Fluent in English □ Assisted by a translator or interpreter

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, D.C. \_\_\_\_\_\_\_\_\_\_\_\_**

**(Clinician Signature) (Date)**

Student intern/extern initials as witness to patient discussion with clinician: \_\_\_\_\_\_\_\_\_\_\_\_