GABRIELLE CZAJA, PT INC.

INFORMED CONSENT FOR TELEHEALTH/E-VISITS

CLIENT NAME: ______________________________________DATE OF BIRTH: ____________________

LOCATION OF CLIENT: _______________________________CLIENT PHONE: ____________________

PHYSICIAN NAME & PHONE: ____

DATE CONSENT DISCUSSED: ____

EMERGENCY CONTACT NAME & PHONE: ____

I understand that telehealth/e-visits use electronic information and communication technologies by a healthcare provider to deliver services to an individual when that individual is located at a different site than the provider; and hereby give consent to Gabrielle Czaja, PT to provide health care services to me via telehealth/e-visits.

I understand there are limitations to telehealth/e-visits, namely the provider is in a different location and cannot provide me direct support, perform hands on procedures or assessment and treatment. I understand there are safety issues where the therapist is not present to support me physically. If I sustain an injury during my telehealth session Gabrielle Czaja, PT will call my emergency contact, my physician and if need be the appropriate first responders.

I understand that I can be photographed or videotaped if the provider and I together deem it appropriate and the provider will inform me this is happening. The photograph/videotape will be part of my medical record and be subject to HIPPA restrictions. If technology fails and the connection cannot be re-established my provider will call me on the above phone number.

I understand my medical information is protected during telehealth/e-visits as in regular in-person sessions.

I understand that I am responsible for payment of telehealth sessions and an appropriate bill will be given to me for my insurance company. I understand if Medicare is my primary insurer, only e-visits are covered by Medicare.

I understand that I have the right to withhold my consent, stop a telehealth/e-visit session in the course of my care without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Gabrielle Czaja, PT Inc. at 202-223-4943. As long as this consent is in force (and has not been revoked) Gabrielle Czaja, PT may provide health care services via telehealth/e-visits.

CLIENT SIGNATURE____DATE:_____________

(Or name and signature of the parent of a minor)

WITNESS: ____DATE:____________

I HAVE BEEN OFFERED A COPY OF THIS CONSENT. PLEASE INITIAL:______