TELEHEALTH SERVICES CONSENT FORM

1. I voluntarily wish to engage in a telehealth visit with my physical therapy provider at Cape Cod Physical Therapy, Limited Partnership (hereinafter "PT Provider").

2. My PT Provider has explained to me that HIPAA-compliant video-conferencing technology will be used to enable the telehealth visit. I understand this visit will not be the same as an in-person, direct patient-physical therapy provider visit due to the fact that I will not be in the same room as my PT Provider.

3. I understand there are potential risks associated with using video-conferencing technology, including (a) the risk of technical interruptions or failures, or (b) the risk of unauthorized access to my healthcare information. I understand that either my PT Provider or I may discontinue the telehealth visit if it is felt that the video-conferencing connections are not adequate or secure for the telehealth visit.

4. I hereby hold harmless and agree not to sue PT Provider, and its parent company, subsidiaries, agents, affiliates, associates, officers, directors, owners, and employees (collectively "Releasees") from any losses or damages due to loss of, or unauthorized access to, my health information caused by or alleged to be caused by technical interruptions, failures, or difficulties in connection with the telehealth services provided by Releasees, to the fullest extent permitted by law.

5. I understand that PT Provider may share my health information with other individuals for scheduling and billing purposes. I further understand that other staff members may be present during my telehealth visit to operate the video-conferencing equipment, as needed, and the above-mentioned individuals will maintain confidentiality of the information obtained.

6. I understand that for each telehealth session, I will be asked to show a photo ID to confirm my identity. Likewise, I have the right to ask PT Provider practitioner to show his/her identification and credentials to confirm his/her identity.

7. By signing this form, I certify that:
   - I have read or had this form read and/or had this form explained to me.
   - I fully understand its contents including the risks and benefits of engaging in the telehealth session.
   - I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
   - I understand my email address will be used for telehealth purposes.

_____	_____	_____
Patient Printed Name	**Email Address**	**Date of Birth**
_____	_____	
Patient or Parent/Legal Guardian Signature	**Date**	