



TELEMEDICINE PROGRAM TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian if under 18)

_____, agree to participate in a telemedicine virtual injury screen and prescribed plan of care. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [**Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that Remote Movement Solutions, LLC (RMS) may have both working affiliations and professional relationships with those specialists that are recommended. RMS will disclose any affiliations working, professional, or otherwise to ensure that the patient is aware in the event a referral to a specialist is made during an injury screen by RMS.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I understand that any injury related to the application of the prescribed treatment (including exercises) will not be the responsibility of RMS. RMS will be responsible for screening and specifically the recommendation of the plan of care based on standard practice measures regulated by the American Physical Therapy Association.



FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my injury screen. I understand that I may withdraw this permission at any time during my evaluation.

Signature of patient (or parent/guardian): _____

Date: _____ Please print the above
name _____