phone: (509) 350-2506
email: cdotson@OYHPT.com
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Consent for TELEHEALTH Physical Therapy Treatment

I understand that I am a patient of Own Your Health Physiotherapy (OYHPT) and I will be receiving my treatment via TELEHEALTH using a secure online platform. Even though OYHPT utilizes a HIPAA secure telehealth platform, information sent over the internet may not always be secure.

I understand that the Telehealth sessions are hands-off sessions and will consist of detailed discussion regarding my condition, visual assessment of my movement patterns, balance, and range of motion. I am responsible for maintaining a safe working space around me during the telehealth session.

I understand that I may be given home exercise program and advice to help me progress towards my goals.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increase strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

Payment: I understand that I am responsible for full payment for this session. OYHPT is an out-of-network provider. I understand that I am able to bill my insurance for this session and I have checked with my insurance provider for possible reimbursement.
I have read the above information and I consent to physical therapy evaluation and treatment.

By signing below, I confirm that I have read all of the above information and I consent to physical therapy evaluation and treatment.

Signature of Patient or Legal Guardian:_____ Date:_____