Telehealth Waiver, Informed Consent and Release Form

I, _____ agree to participate in Telehealth services for physical therapy provided by Physioforce, LLC
I hereby give permission for my minor child _____ to participate in Telehealth services for physical therapy provided by Physioforce, LLC

What is Telehealth? Telehealth is the use of electronic information and telecommunication technologies to support and promote long distance clinical health care, patient and professional health-related education, public health, and health administration. Physical therapy care will be performed in a Synchronous, real-time, 2-way audiovisual session where interaction will be performed virtually or electronically.

- THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) MY PARTICIPATION IN TELEHALTH WITH PHYSIOFORCE IN ANY ACTIVITY, CLASS PROGRAM, OR INSTRUCTION (2) HOME EQUIPMENT THAT MAY MALFUNCTION OR BREAK (3) ANY SLIPPING AND/OR FALLING WHILE PARTICIPATING IN TELEHALTH SERVICES WITH PHYSIOFORCE, LLC

What is the cost? Most insurance companies reimburse for Telehealth services. However, there is a potential risk that this will not be covered. By signing this form, you acknowledge that you could be held responsible for the cost of each physical therapy session performed through Telehealth. Because there is A difference between Telehealth vs face to face interaction, the cost out of pocket will be $58 per session. I understand that I am responsible for any payment or co-payment for scheduled physical therapy sessions. I understand that I am responsible for attending all sessions scheduled for the physical therapy for mine or my child's follow-up visits to receive proper instruction and guidance of the established plan of care from your physical therapist.

Informed Consent with Telehealth. I consent during Telehealth Physical Therapy sessions that to being recorded, photographed, or videotape and to the storage of this encounter data. The storage of this information will be kept confidential in a secure location and will be stored up to 6 years from the date of service. **Hold Harmless Clause**: I do not hold Physioforce, LLC or its Physical Therapists responsible for information lost due to technology failures. Because this is being performed virtually there is a risk that a connection can be interrupted. In this event the physical therapist will call you through your phone to aid with guidance to either reschedule this session or continue through different means of technology.

Disclaimer: Telehealth services performed by Physioforce, LLC for physical therapy are not the same as face to face interaction. By signing this form, you understand that results may vary for these reasons. Telehealth services will not have a hands-on or referred to as manual treatment and guidance through exercise will be given through verbal cueing virtually through real-time synchronous format.

Although this program is designed for physical therapy & rehabilitative purposes, there is minimal risk of injury with participation in the established program from your physical therapist. I understand that I cannot hold Physioforce, LLC responsible for any injuries sustained in this process.

Assumption of Risk

- Outside of the injury being seen for, to the best of my knowledge I/my child is in good physical condition and have no disease, physical limitation, health concern or injury that would be aggravated or would be the cause of any injury sustained, before, during or as a result of my participating in activities related either directly and/or indirectly to participation in physical therapy at Physioforce, LLC. If additional past medical history is present, I understand that I have disclosed this information to my physical therapist to make appropriate adjustments to care.
- I recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure; fainting; disorders in heartbeat; heart attack; and, in rare instances, death.
- I understand that I/my child will be monitored by a licensed physical therapist through Telehealth Syncrhnous real-time audiovisual means and that is providing instruction during this program; however I also understand that as a result of participation in an exercise program, I/my child could suffer an injury.
- I understand the physical therapist will perform a initial evaluation to determine the appropriateness of exercise intervention. I also recognize that an examination by a physician should be obtained by all participants prior to involvement in any exercise program. If I have chosen not to obtain a physician's permission prior to beginning this exercise program with Physioforce, LLC**,** I hereby agree that I am doing so at my own risk.
- For direct-access cases, I understand that a physician's referral is not needed for conducting physical therapy. However, upon permission my primary care provider will be contacted after the initial evaluation about my current. If progress is not obtained within 30 days of the initial evaluation, I understand a referral to outside physician is required by Ohio state law.
- In any event, I acknowledge and agree that I assume the risks associated with any and all activities and/or exercises in which I/my child participate.

_____ _____
Name of minor child (printed) Signature of minor child

_____ _____
Name of parent/guardian (printed) Signature of parent/guardian and date

_____ _____
Name of client (printed) Signature of client and date