ALISON THOMSON
PHYSIOTHERAPISTS INC.
WWW.CENTURYCITYPHYSIO.CO.ZA

**Consent to Receive Telehealth Services**

(children 12 years or older, adults 18 years of age and older and of sound mind)

Patient full names and surname: _____

Patient identity number: _____

Patient medical scheme name and number: _____

Patient address: _____

Patient email address and mobile nr: _____

**Agreement to Telehealth:**

I, the Patient, hereby agree:

1. To be serviced by the Practitioner from this Practice by means of electronic media (Skype, Zoom or similar; and/or by telephone and/or by Whatsapp Call or FaceTime call (delete what is not applicable), as authorized by the HPCSA for the period of the Covid-19 Lockdown.

2. I understand that this platform will be used to render healthcare services to me, and that the usual consent processes will be followed (i.e. I will be informed of my health status, as well as the benefits, risks and implications of the care). I understand that I can opt out of receiving care, at any stage, but acknowledge that it may not be in my best interest and I therefore release the Practitioner from legal liable for this.

3. There is no subscription required when using the electronic platforms mentioned above, such as costs for the Applications ("Apps") used, but I understand that I will carry my own costs of any infrastructure and/or running costs associated with such service being rendered e.g. the data used, the telephone and/or computer, etc.

4. That the Practitioner may encourage me to present myself for a face-to-face consultation at a healthcare facility close to me, if he/she is in doubt that the telehealth consultation is in my best interest, provided that it would be safe for me, the Practitioner and others, to do so.

5. That I will be billed for a consultation at the Discovery Health rate or other Medical aid that has authorised Telehealth and supplied treatment codes for 30 minutes or any part thereof. I also understand that, due to the nature of the current pandemic, that the Practitioner may have to give urgent attention to other patients, and/or have to move my appointment to a later or earlier time or day.

6. That my medical scheme may, or may not cover the costs of this care. I undertake to cover any shortfall that my scheme does not cover, which may be the full amount. However, I understand that the HPCSA allows such care during the time of the Covid Pandemic, and that certain services must be funded by my scheme in full.

7. To record-keeping of the session, i.e. the Practitioner's notes, which are required by law [and, where applicable: ... and with my prior consent, to the recording of the live session as video and sound recording.]

8. That the service may have limitations relating to technology, such as data- and internet failures (e.g. dropped calls or bad reception).

9. That, although the Practitioner will adhere to the existing rules relating to confidentiality:
a. I understand that I must take the necessary precautions at home to ensure my confidentiality during telehealth service provision;
b. I understand that, should I want a family member, caregiver, parent or other person to attend the session with me (in person or through a remote internet connection), I will provide my written consent to such attendance prior to the consultation. I understand that without this, should such a person be in attendance, the engagement may be cancelled or rescheduled;
c. I understand that, and agree that, should the practitioner believe that I may have been exposed to Covid-19 and/or do have Covid-19, s/he would refer me for tests, and I understand that the results of such tests must be reported, by law, to the NICD – National Institute of Communicable Diseases. I, therefore, freely and voluntarily consent to this service, and I understand the implications thereof, including the costs related to it.

Signed at _____(place) on_____ (date)

Patient signature

_____

which the Practice and Patient agree can be electronically affixed.