Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Virtual Care
Client Consent Form

Affix Patient Label - or -

Patient Name _____

V # _____

DOB _____

Patient Email: _____

In order to support you with your rehabilitation goals, staff at the Hotel Dieu Shaver Health and Rehabilitation Centre (HDSHRC) are providing your rehabilitation program using video conferencing over the internet, as well as via telephone.

I acknowledge and agree that both myself and my healthcare providers are required to maintain strict confidentiality and follow the Patient's Rights and Responsibilities during video or teleconferencing, just as they would during an on-site appointment. It is important to ensure that only you and your health care provider are present for the videoconference unless having other individuals present was discussed and consented to by both of you prior to starting the session.

HDSHRC will take measures necessary to protect your personal health information. However, any internet based communication is not 100% guaranteed to be secure/confidential. If a breach should occur, HDSHRC will follow all procedures outlined in the Personal Health Information and Protection Act of 2004 including informing you as soon as possible that a breach has occurred.

You are encouraged to read the "Welcome to Rehab Virtual Care" document which includes Tips to Make your Virtual Care Safe. This information can be found on the Hotel Dieu Shaver Health and Rehabilitation Centre website at www.hoteldieushaver.org. If you agree to provide this consent, please respond verbally or in writing to the statement below. If you still have concerns or questions, the care provider noted below will be happy to address them or bring them to the appropriate people for answers.

I, _____ consent to Virtual Care and I acknowledge and agree that Hotel Dieu Shaver Health and Rehabilitation Centre has made me aware of the measures for confidentiality, technical requirements and that HDSHRC is not liable for any internet breach of confidentiality, internet disruption, or unforeseen breach of confidentiality when providing my care online.

Patient Name	Patient Signature:	Date (YYYY/MM/DD)

OR

Patient Verbal Consent Provided ☐ YES ☐ NO

Staff Name	Staff Signature	Date (YYYY/MM/DD)
Witness Name	Witness Signature	Date (YYYY/MM/DD)

Consent is an ongoing process which means that you may change your mind after giving verbal consent or signing this consent form, you have the right to withdraw your consent at any time.

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