Optimized Wellness Center

TELEMEDICINE CONSULTATION CONSENT

_____ (hereinafter "**I**") seek the telemedicine consultation of Optimized Wellness Center ("**Practice**"). I am executing this Consent to Participate in Telemedicine Consultation ("**Telemedicine Consent**") to verify and confirm my discussion with Dr. Tim Heath, a licensed Doctor of Chiropractic and/or other OWC associates (**"Provider"**) regarding the risks, benefits, and alternatives to the telehealth consultation services through Practice. I am seeking the telemedicine consultation services of Practice for my own purposes and not on behalf of any third party. I understand that I am a participant in the decision-making process, and I am free to decline services or recommendations at any time. I retain the option to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I acknowledge that the Provider may, in his or her sole discretion, determine whether the nature of my consultation is inappropriate for telemedicine, and may require me to come in for an in-person consultation. I agree to bring to the attention of Practice, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of the Provider for further explanation until I have a full understanding before giving consent to any counseling or services.

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1. **Purpose.** The purpose of this form is to obtain your consent for the use of telemedicine consultations with the Provider to assist in the care and services provided by the Practice and ultimately to assist to improve your overall health and wellbeing.

2. **Nature of Telemedicine Consultation.** Telemedicine involves the use of audio, video or other electronic communications to interact and review with you, consult with your healthcare Provider and/or review your medical information for the purpose of consultation, therapy, follow-up and/or educational purposes. During your telemedicine consultation, details of your health history and personal history information may be discussed with other health professionals. Additionally, a physical examination of you may take place via video, audio, and/or photo recordings. I hereby consent to allow the Provider to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits. The information gathered may be used to directly facilitate better health outcomes and/or with your permission facilitating a second opinion with the appropriate health professional of your health status. I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation, and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

3. **Risks, Benefits and Alternatives.** The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel to the Practice. Additional benefits are that patients may be consulted with and their concerns addressed earlier which can contribute to improved outcomes and less costly treatments. Potential risks of telemedicine include that because of your specific condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Failure to follow the instructions and recommendations of the remote practitioner could result in an adverse reaction to the medical treatment rendered.

The Practice has taken the following steps to ensure the privacy of the telemedicine consultation:

- We use only HIPAA compliant software through our Electronic Health Record (EHR) software, teleconferencing software, and other electronic service providers;
- We have taken steps to encrypt data stored on local devices, if any;
- We use password protected screen savers and data files; and

- We use other reliable authentication techniques and safeguards, both electronically and physically, to reduce the likelihood of patient data or privacy breaches.

Good faith measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption are employed. In rare instances, technology failure may lead to the loss of information provided through telemedicine consultations. Additionally, in rare instances, security protocols could fail causing a breach of patient privacy. In rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reactions, or other judgment errors. You agree to hold the Provider and the Practice harmless from any such information loss, and any resulting judgments or decisions, due to technical failures outside of their agency or control. The quality of transmitted data may also affect the quality of the services provided via the telemedicine consultation. The alternative to telemedicine consultation is a face-to-face visit with the Provider.

4. **Medical Information and Records.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation shall not occur without your consent.

5. **Confidentiality.** All existing confidentiality protections under federal and state law apply to information used or disclosed during your telemedicine consultation. However, there are both mandatory and permissive exceptions to confidentiality, which may allow or require disclosure of information used or disclosed during the telemedicine consultation. You will be informed of any parties who will be present from the Practice during your telehealth consultation and will have the opportunity to exclude anyone from attending the consultation.

6. **Rights.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the right to be informed of and object to videotaping or other recordings of the telehealth consultation.

By signing below, I acknowledge and certify that:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I have had opportunities to ask questions and have had them answered to my satisfaction.
- I understand that it is my duty to inform my healthcare Practitioner of any interactions regarding my care that I may have with other healthcare providers.
- I have read and fully understand the foregoing Telemedicine Consent, and I have all of the knowledge I currently desire.
- I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

PATIENT NAME (print)**: _____SIGNATURE: _____**
TITLE (if legal representative or guardian): _____DATE: _____

I have explained this Informed Consent and answered all questions in layman's terms and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

OWC NAME (print)**: _____SIGNATURE: _____**