Lilac Natural Medicine

COVID-19 Consent

I, _____, consent to being treated knowing that despite adherence to enhanced guidelines, there is a potential risk of exposure to COVID-19.

_____ _____

Patient/Parent/Guardian Signature Date

Consent for Telemedicine Services

Introduction: I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and herby consent to receiving healthcare services via telemedicine. **Initial: _____**

Privacy & Payment: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that I will have access to my medical records should I request a copy in writing, for a reasonable fee. I understand that insurance coverage for telemedicine services is not guaranteed, regardless of the COVID-19 emergency and related Emergency Orders issued by the Governor, or any other legislation passed in relation to the pandemic. **Initial: _____**

Risks & Benefits: I understand that possible benefits of telemedicine include improved access to medical care, more efficient medical evaluation and management, and obtaining expertise of a specialist from a distance. I understand that, as with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the doctor. Delays in medical evaluation and treatment could occur due to deficiencies or failures of technology, in addition to the inability to conduct a physical exam. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. **Initial: _____**

Consent: I understand that I have the right to withhold or withdraw my consent to the use of telemedicine at any time in the course of my care without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Lilac Natural Medicine, LLC. **Initial: _____**

_____ _____

Patient/Parent/Guardian Signature Date