Functional Integrative Practice of Dr. Nadia Ali
Functional Holistic Healing
995 Old Eagle School Road, suite 311
Wayne, PA, 19087
PH: 610-363-3973
Fax: 484-631-1327
website: www.theholistichealing.org

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ Date of Birth: _____

Telemedicine involves the use of electronic communications to provide patient care, share individual patient medical information, remote monitoring and tele-pharmacy. Functional Holistic Healing, and/or its consulting physicians may deliver medical care to you via Telemedicine. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) patient medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; and (5) output data from medical devices and sound and video files.

Expected Benefits of Telemedicine:

- Improved access to medical care
- Lower cost and greater efficiency to receive medical evaluation and management
- Obtaining expertise of a specialist

Possible Risks:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies
- In very rare events, security protocols could fail, causing a breach of privacy of your personal health information
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Consent:

You acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Telemedicine services.
2. I understand that Providers offer Telemedicine services, but that these services do not replace the relationship between me and my primary care doctor.

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3. I also understand it is up to the provider to determine whether or not my needs are appropriate for a Telemedicine encounter.
4. I understand that federal and state law requires health care providers to protect the privacy and the security of my personal health information. I understand that Providers will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that Telemedicine may involve electronic communication of my personal health information to other medical practitioners who may be located in other areas, including out of state.
5. I understand there is a risk of technical failures during the Telemedicine encounter beyond the control of Providers. I agree to hold Providers harmless for delays in evaluation or for information lost due to such technical failures.
6. I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason.
7. **Emergency Situations**: I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Providers are not able to connect me directly to any local emergency services.
8. I understand the alternatives to Telemedicine consultation, such as in-person services are available to me, and in choosing to participate in a Telemedicine consultation, I understand that some parts of the services involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Provider (e.g. labs or bloodwork).
9. I understand that I may expect the anticipated benefits from the use of Telemedicine in my care, but that no results can be guaranteed or assured.
10. I understand that my personal health information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Provider in order to operate the Telemedicine technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the Telemedicine examination; and/or (3) terminate the consultation at any time.
11. I understand that I will not be prescribed any Drug Enforcement Agency controlled substances nor is there any guarantee that I will be given a prescription at all.
12. I understand that if I participate in a Telemedicine consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

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13. I understand that in the event of any problem with the website or related services, I agree that my sole remedy is to cease using the website or terminate access to the service. Under no circumstances will Provider or any of its subsidiaries, affiliates or vendors be liable in any way for the use of the Telemedicine services, including but not limited to, any errors or omissions in content or infringement by any content on the website of any intellectual property rights or other rights of third parties, or for any losses or damages of any kind arising directly or indirectly out of the use of, inability to use, or the results of use of the website, and any website linked to the website, or the materials or information contained on any or all such websites.
14. I agree that I will not hold Provider, its subsidiaries, affiliates or vendors liable for any punitive, exemplary, consequential, incidental, indirect or special damages (including, without limitation, any personal injury, lost profits, business interruption, loss of programs or other data on my computer or otherwise) arising from or in connection with my use of a Telemedicine consultation whether under a theory of breach of contract, negligence, strict liability, malpractice or otherwise, even if we or they have been advised of the possibility of such damages.
15. I understand that if I access Telemedicine services from a location outside of the United States, that I do so at my own risk and initiative and that I am ultimately responsible for compliance with any laws or regulations associated with my use.
16. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
17. I have had a direct conversation with my doctor and/or the office staff , during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____
Patient's/parent/guardian signature Date Time

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_____	_____	_____
Witness signature	Date	Time