Informed Consent to Treat

Integrative Healthcare of Colorado, LLC

1. I _____ (patient name) give permission for Integrative Healthcare of Colorado to give me medical treatment.

2. I understand the Integrative Healthcare of Colorado is a fee for service medical practice. Integrative Healthcare of Colorado will *not* submit paperwork to my insurance provider and does not accept Medicare or Medicaid.

   I understand that:
   - Integrative Healthcare of Colorado will not send my medical record information to my insurance company. I may submit paperwork to my insurance company for reimbursement.
   - I must pay for my appointment the day of service via credit card.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - I understand that I have the ability and right to be able to select/direct which pharmacy my prescriber uses to fill my medication orders.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print name Date

Telehealth Informed Consent to Treat

Integrative Healthcare of Colorado, LLC

I, _____
hereby consent to engage in telehealth with Integrative Healthcare of Colorado, LLC (IHC) as an adjunct to my medical care (I will retain care with my primary care provider while receiving care with IHC). I understand that "telehealth" includes the practice of diagnosis, consultation, and treatment using interactive audio and video communications.

Because of recent advances in communication technology, the field of telehealth has evolved. It has allowed individuals who may not have local access to a specialized integrative health professional to use electronic means to receive services. I understand that an important part of an appointment is sitting face to face with an individual, where nonverbal communication (body signals) and physical evaluation are readily available to both provider and patient, but this will not be present in a telehealth session. I understand that because of this, telehealth may or may not be as effective as an adjuct therapy and therefore both my provider and I must pay close attention to my progress and periodically evaluate the effectiveness of this type of appointment.

I understand that I have the following rights with respect to telehealth:
I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my appointment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality,
including, but not limited to reporting child and elder abuse; expressed threats of violence or dangerousness, and when I make my mental or emotional
state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the
part of my provider that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of
my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by
unauthorized persons.

In addition, I understand that telehealthbased services and care may not be as complete as facetoface services. I also understand that if my provider believes I would be better served by another form of treatment (e.g. face-toface services) I will be referred to a provider that can do in-office appointments
in my area.

I understand that I have a right to access my medical information and copies of medical records in accordance with the law.

I have read and understand the information provided above. I have discussed it with my provider, and all of my questions have been answered to my satisfaction.

Patient's Signature	Date
Parent or Guardian Signature (for children under 18)	Date
Print name	Date