



**CONSENT FOR TELEHEALTH CONSULTATION**

1. I understand that I am voluntarily engaging in a telemedicine consultation done by a “store and forward” route with Cultivating Resilience, LLC. I understand that I am submitting a health questionnaire that will contain my basic medical history, current symptoms (if any), and goals for treatment that will be reviewed by a licensed medical provider. The medical provider will then approve the desired medical interventions and/or prescriptions being requested after reviewing my submitted information. My request will be approved pending any contraindications to therapy and I will be notified by email within 24 hours. If the medical provider does not approve the interventions and/or prescriptions being requested, I will be notified by email and will be refunded, in full, the purchase price of any prescriptions or treatments.
2. I understand that the health questionnaire I fill out on this website and which will be submitted to the medical provider will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider. I understand that this is a convenience and a courtesy provided by Cultivating Resilience, LLC.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that, if there is another individual present during the telehealth consultation (if done via video or phone), I will be informed of their presence and I will also disclose if there is another individual with me. It is agreed that these individuals will maintain confidentiality of the information obtained. 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/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with Cultivating Resilience, LLC and to seek an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation via a “store and forward” route.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through Cultivating Resilience, LLC will be limited or not done at all. I understand that I am submitting a health questionnaire that will contain my basic medical history, current symptoms (if any), and goals for treatment.
8. Telemedicine services offered by Cultivating Resilience, LLC are not an emergency service and, in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care facility.

By signing this form, I certify: (FORM WILL BE SIGNED ELECTRONICALLY IN YOUR EMR)

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions, if desired by emailing Cultivating Resilience, LLC, and have had them answered to my satisfaction before submitting the requested information

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name