

Informed Consent for Telemedicine Naturopathic Treatment

I, _____, hereby authorize Dr. Van Dusen of Vital Source Natural Medicine PLLC to perform diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as **Telemedicine**. I understand that I will not be seeing her in an office setting and that she will not be my primary care provider and I must maintain a primary care provider for physical examinations and other diagnostic and screening procedures. I understand that I must be present in the state of Washington when communicating with the doctor.

I recognize the potential risks and benefits of these procedures as described below:

Expected Benefits:

- Improved access to medical care when I am unable to travel to Dr. Van Dusen's office.
- More efficient medical evaluation and management.

Potential Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information (understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine).
- In rare cases, a lack of access to complete medical records or information transmitted may result in adverse drug interactions, allergic reactions, or inappropriate medical decision making by the physician.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Van Dusen:

- 1) my suspected diagnosis or condition
- 2) the nature, purpose and potential benefit of the proposed care
- 3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
- 4) the probability or likelihood of success
- 5) reasonable available alternatives to the proposed treatment / procedure
- 6) the possible consequences if treatment or advice is not followed and/or nothing done.

With this knowledge I voluntarily consent to utilizing telemedicine realizing that no guarantees have been given to me by Dr. Van Dusen and Vital Source Natural Medicine PLLC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

Signature of patient: _____ Date: _____
(Parent/guardian if minor)