DR. ADEOLA MEAD, ND
MASA INTEGRATIVE CLINIC. 8012 15TH AVE NW. SEATTLE, WA 98117

Telemedicine Informed Consent Form

PURPOSE: The purpose of this form is to obtain consent to participate in a telemedicine consultation

NATURE OF TELEMEDICINE CONSULT: I understand that telemedicine includes the practice of health care assessment, diagnosis, consultation, treatment consideration, and education using audio and video communications.

MEDICAL INFORMATION, RECORDS, AND CONFIDENTIALITY: All existing federal and Washington state laws regarding access to your medical records and confidentiality protections apply to information disclosed during your telemedicine consult.

RIGHTS: I may withhold or withdraw consent to the telemedicine consult at any time.

LICENSING AND DISPUTES: Dr Mead is the state (WA) in which she works. I agree that any disputes arising from the telemedicine consult shall be resolved in Washington, and that Washington law will apply to all disputes.

RISKS AND CONSEQUENCES: I acknowledge that I have been previously seen by my primary care provider and specialist for my current health problem and that they have ruled out or are already treating any major diseases causing or contributing to my condition. I understand that not having done so can result in serious injury or death, and that Dr. Mead cannot rule out or diagnose many diseases while consulting with me via telemedicine, nor do I expect Dr Mead to do so. I understand that I must see my local health care provider(s) in person in order to be evaluated for all conditions.

BENEFITS: I want to consult with Dr Mead about non- life-threatening conditions, or I want to consult with Dr Mead about additional help treating a condition for which I also see in-person a healthcare provider who is responsible for managing that condition.

By signing this form, I acknowledge the following:

I have read and understand this form.

I have been given ample time to ask questions and my questions have been answered to my satisfaction.

I have seen my local doctor and specialist regarding my current condition. Telemedicine does not replace the need to see my local doctor.

In the case of technology or equipment failures during telemedicine sessions, my consult may need to be rescheduled.

I will be required to pay for my telemedicine consult(s).

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Patient Signature (or parent or guardian) :

Date of Signature