Dr. Diane Lee
Seattle Naturopathic and Acupuncture Center

Informed Consent for Telehealth Naturopathic Treatment

I,_____, hereby authorize Dr. Lee to perform diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as **Telehealth.** 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 recognize the potential risks and benefits of these procedures as described below:

Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes and aggravation of present conditions.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

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. Lee:

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.

Starting February 2021, at the end of each week, Seattle Naturopathic and Acupuncture Center will charge the card on file for any patient responsibility that is owed for telehealth visits.

Patient Initial: _____ Date: _____

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Dr. Lee** 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: _____