Confidentiality Agreement & Informed Consent for Phone Visits & Telemedicine

This consent is for the use of electronic communications to allow us to provide patient care. The virtual provision of our services allows us to use information gathered electronically for diagnosis, therapy and follow-up and/or education. As with any Naturopathic medical procedure, there are potential risks associated with Telemedicine.
We use our best efforts to ensure that your personal and confidential information is kept securely and our electronic systems will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data, and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. However, by agreeing to receive our services virtually, you acknowledge and agree that:
1. In rare cases, information transmitted may not be of sufficient quality to allow for appropriate therapeutic decision making. I understand that a phone and/or telemedicine consultation will not be the same as a direct patient/health care provider visit, due to the fact that I will not be in the same room as my health care provider.
2. I understand that some parts of the consultation involving physical tests/exams may need to be deferred until an in-person appointment can be conducted.
3. Although all efforts have been made to ensure my privacy, I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider, or I, can discontinue the telemedicine visit, if it is felt that the videoconferencing connections are not adequate for the situation.
4. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
5. We cannot guarantee the availability of Telemedicine, which may become unavailable due to system backup procedures, Internet traffic volume, upgrades, overload of requests to the servers, general network failures or delays, or any other cause, which may from time to time, make our virtual services inaccessible to you.
6. I understand that my healthcare information may be shared with other individuals who are employed by the clinic, for scheduling and billing purposes.
7. I understand that billing will occur from my practitioner/clinic for this service.
By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given an opportunity to ask questions and that any questions have been answered to my satisfaction.

Please send this with signed online signature, unless able to print and scan, to ***rdwcinfo@protonmail.com*** *or fax* ***403-346-1309****.*

Date: _____ Client's Name (Please Print):_____

Signature of Client or Guardian:_____

Date: _____ Signature of Naturopathic Doctor: _____