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TeleMedicine Patient Informed Consent Form

I, _____ (patient printed name) hereby consent to receive TeleMedicine video conference care from my naturopathic physician, Dr. Jeana Kimball. I am an established patient and have previously met with Dr. Kimball in person for sessions in her office. The therapeutic relationship is established, and I consent to TeleMedicine at this time to maintain the continuity of my care.

I understand that TeleMedicine is used when it is not advisable or available for me to visit my naturopathic physician in person. Reasons to use TeleMedicine may include but are not limited to cases of emergency, illness, quarantine, transportation problems, travel, illness, residential move.

I understand that the rules of confidentiality in TeleMedicine are the same as the rules of confidentiality stated in the Junction Naturopathic Medicine Informed Consent document I have read and signed prior. I understand that the laws protecting the privacy of my medical information also apply in TeleMedicine. I understand that the Notice of Privacy content I previously read and signed also apply to TeleMedicine. I understand that no electronic media is perfect and on occasion, breaches of privacy may occur with TeleMedicine.

I understand that because my naturopathic physician is licensed by Washington State, and her office is in Washington State, Washington laws apply to her standards of care and to the handling of my medical records. I understand that if I am out of state, the laws of that state may also apply.

I understand that it is my responsibility to help make my TeleMedicine visits successful. I agree to the best of my ability, to arrange a safe, quiet, private place with lighting and internet connection in which to participate in my TelMedicine appointment. I agree to have my telephone (and charged if a cell phone) near me during sessions as a backup should there be a disruption in video service due to technical difficulties.

I understand that I may cancel a TeleMedicine appointment, giving Dr. Kimball 48 hours advanced notice, as stated in our original Informed Consent agreement. I agree that my late cancellation fee as stated in that document also applies in TeleMedicine.

I understand that if TeleMedicine proves unsuitable for my needs, I can decline future visits without jeopardizing my future access to direct in-office visits with Dr. Kimball.

I have read, understood and agree to the content stated above.

_____ Patient Name, printed

_____ Patient Signature

_____ Date