Mountain View Natural Medicine
INTEGRATIVE PRIMARY CARE

Telemedicine Consent Form

PATIENT NAME: _____ **DATE OF BIRTH**: _____

LOCATION OF PATIENT: Patient MUST be in the state of Vermont to receive telemedicine services:

_____

Physical office locations:

185 Tilley Dr, South Burlington VT 05403
Lorilee Schoenbeck, ND Vermont State License Number 099-0000005
Nicole Kearney, ND, Vermont State License Number 099-0122006
Adriane Morrison-Taylor ND, Vermont State License Number 099-013408

302 Mountain View Drive, Colchester, VT 05446
Michael Gravett, ND, Vermont State License Number 099-0120401
Nina Meledandri ND, LAc. Vermont ND license 099-0129165. VT Acupuncture license: 091-0129382

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he /she is located at a different site than the provider; and hereby consent to the providers of **Mountain View Natural Medicine** providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review /audit.

I understand that I will be responsible for any copayments or co-insurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Mountain View Natural Medicine at 802-860-3366.

As long as this consent is in force (has not been revoked) the providers of Mountain View Natural Medicine may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient):

_____ **Date**: _____

If authorized signer, relationship to patient: _____

I have been offered a copy of this consent form (patient's initials): _____ ***Please fax completed form to 802-497-0461***
or if you use our portal Patient Fusion, you may scan and send it as a message to your doctor.