Listen Nutrition
Amber Watkins, RN
748 N. 66th Way, Mesa AZ 85205
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Informed Consent for Telemedicine Services

Purpose: The purpose of this form is to provide you with information about telemedicine and to obtain your informed consent to participate in a telemedicine health service provided by Amber Watkins dba Listen Nutrition ("Provider").

Nature of Telemedicine: Telemedicine involves the delivery of health care services, including assessment, nutritional diagnosis, treatment, and education, using interactive audio, video, and data communications. It involves the use of electronic communications to enable health care providers at different locations to share individual medical information for the purpose of improving patient care. A patient located at an "originating site" and a provider located at a "distant site" exchange information for evaluation, nutritional diagnosis, consultation, or treatment of the patient. The delivery of healthcare via telemedicine allows the patient and provider to see and hear each other in real time, much as they would during a traditional face-to-face appointment. Your telemedicine encounter may include, for example, live two-way audio and video communications and physical and mental examinations.

Benefits: Potential benefits of telehealth include: (i) access to care if you are unable to travel to my office; (ii) more efficient evaluation and management; and (iii) during the COVID-19 pandemic or any other health pandemic, reduced exposure to patients, staff and other individuals at a physical location.

Risks: Potential risks of telehealth include: (i) my Provider's inability to conduct a hands-on physical examination of me and my condition; and (ii) delays in evaluation and recommendations due to technical difficulties or interruptions, distortion of diagnostic reports resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures.; (iv) breach of privacy of protected health information due to security breaches or failures.

Alternatives: Alternative methods of care may be available to you. Your Provider will explain any such options to you, and you may choose an available alternative form of care at any time.

Follow-up Assistance: In case of an emergency, you will dial 911 or go directly to the nearest hospital emergency room.

Consent: I consent to receive telemedicine services from Amber Watkins dba Listen Nutrition. I understand and agree:

1. Telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.
2. I have the right to object to the use of a telemedicine service without prejudice to any future care or treatment and without risking the loss or withdrawal of any health benefits to which I am entitled.
3. If there are costs to me associated with my telemedicine encounter, a health care professional will discuss those costs with me at my request.
4. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and I agree that my Provider may provide my confidential personal health information to other medical providers who may be located in other areas, including on rare occasions to providers outside the State.
5. I have the right to inspect and obtain copies of all information received and recorded during any telemedicine session, subject to the policies of the physicians and facilities involved in my care. I may be charged a fee for copies of my records in accordance with applicable State rules.
6. My Provider will inform me who will be present at the originating site and the distant site during the telemedicine service and I have the right to exclude anyone from either site, if I so choose.'
7. I have the right to discuss the risks and benefits of all courses of treatment proposed by my health care provider(s), together with any available alternatives.
8. I understand the need to provide a full and accurate medical history, current or previous medical care, including any pre-existing conditions, to my telemedicine providers so that they can accurately determine what services I need. I further understand that my Provider's advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me.
9. I understand that the level of care provided by my Provider is to be the same level of care that is available to me through an in-person medical visit. However, if my Provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest hospital emergency department or other appropriate health care provider.
10. I understand that the degree of care is limited to the scope of practice for a Registered Nurse and Clinical Nutritionist. I may be treated for current medical diagnoses but will not be diagnosed by Amber Watkins, RN. Any lab or exam findings requiring medical care will be referred back to your Primary Care Provider or emergency facility as appropriate.
11. I understand that Amber Watkins, RN cannot discontinue any medication prescribed by my doctor.
12. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
13. During my visit, if I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am the person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.
14. I have read and understand the information provided above and all of my questions have been answered to my satisfaction.

By signing below, I hereby consent to Amber Watkins dba Listen Nutrition providing nutritional care services to me via telemedicine.

_____ _____
Signature of Patient or Authorized Patient Representative Date

_____ _____
If not Patient, Printed Name Relationship to Patient

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Notice of Privacy Practices ("Privacy Notice") Consent Form

Amber Watkins, RN dba Listen Nutrition ("Provider") will protect the privacy of _____'s health information and will not use or disclose it except as permitted by law. Provider's privacy policies are more fully described in the Privacy Notice, which is available for review and download here: _____. By signing this Consent, I acknowledge receipt of the Privacy Notice and consent to my Provider's use and disclosure of my health information in accordance with its terms. I understand that all existing confidentiality protections that apply to in-person treatment apply to telehealth services.

[*For certain states only*] By signing this consent electronically, I authorize my Provider to disclose information related to HIV/AIDS for treatment, payment, health care operations, and other purposes consistent with the Privacy Notice. I may revoke consent by sending written notice as required by the Privacy Notice. Revocation will be effective upon receipt, except to the extent that my Provider has already taken action in reliance on my consent.

_____

By signing below, I hereby consent to Listen Nutrition's Notice of Privacy Practice.

_____ _____
If not Patient, Printed Name Date

_____ _____
Signature of Patient or Authorized Patient Representative Relationship to Patient

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Payment Policy Consent Form

In exchange for receiving telemedicine services with Amber Watkins, RN dba Listen Nutrition ("Provider") I acknowledge, understand and agree that:

1. I will pay at time of service any required payments, outstanding balances, lab fees, supplement purchases, and delinquent accounts unless another payment has already been agreed upon by Provider.
2. By providing my credit card information and receiving telehealth services, I: (i) authorize Provider to charge my credit card for any and all unpaid amounts that Provider determines are my responsibility, and (ii) agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that my Provider may charge my credit card for such amounts at the end of my telehealth visit or at a later date.
3. I will be billed for all unpaid balances deemed by Provider or my insurer to be my responsibility and agree to pay such amounts in full. Provider will charge late fees of 1.5% per month on unpaid balances starting 30 days after the first statement, as well as a $30 fee for returned checks. Delinquent accounts may be turned over to a collection agency at which time I am responsible for the collections charge and all associated legal fees in addition to the amount owed.
4. Provider reserves the right to deny non-emergency services if my account is delinquent.

_____

By signing below, I hereby consent to Listen Nutrition's payment policies.

_____ _____

Signature of Patient or Authorized Patient Representative Date

_____ _____

If not Patient, Printed Name Relationship to Patient