WHOLE CHIROPRACTIC HEALTHCARE

Telehealth Informed Consent

As a telehealth provider, Whole Chiropractic Healthcare must inform patients or consultants providing patient data of the following:

- The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery.
- The knowledge, experiences, and qualifications of the patient or consultant providing patient data and information to the provider of the telehealth services may not and need not be completely known to and understood by the provider.
- The quality of transmitted data may affect the quality of services provided by the provider.
- Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- Telehealth services may not be provided by correspondence only.

That being understood, Whole Chiropractic Healthcare will at all times endeavor to collect the best information and make the best determinations and recommendations possible given the telehealth format.

Lastly, telehealth is a novel offering for many insurances and providers. Whole Chiropractic Healthcare has done its best to advise you of your possible financial responsibility prior to your telehealth appointment. As with all claims, if your insurance carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim. As such, after 90 days of non-payment by the carrier you are responsible for any outstanding balance up to and not to exceed the current discounted non-insurance rate. If after 90 days, WCH is paid by your insurance carrier any claim that you had previously covered, you will be reimbursed the balance, or you may apply the balance to future charges.

I have read (or have had read to me) the above explanation. By signing below, I state that I have weighed the risks involved in treatment via telehealth, and I have decided that it is in my best interest to participate in this treatment format. Having been informed of the risks and limitations, I hereby give my consent to telehealth treatment.

_____	Thomas K. Hyland Robertson, DC
Patient Name (please print)	Doctor Name
_____	_____
Signature of Patient (or Patient Consultant/Guardian)	Signature
Dated: _____	Dated: _____