Telehealth Consent Form

Medical Nutrition Therapeutics LLC

1. I hereby authorize Medical Nutrition Therapeutics LLC to use the telehealth practice platform for telecommunication for evaluation, testing and counseling on my medical condition(s).

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

6. I agree that payment for services on the telehealth platform is due 48 hours prior to consultation.

Name:

First Name _____ Last Name _____ Date of Birth _____

Signature _____

☐ I agree to terms and conditions.