Range of Motion Chiropractic

TELEHEALTH DISCLAIMER

I hereby consent to engaging in telehealth with a Range of Motion Chiropractic. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical information, both orally and visually, to health care practitioners.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my treatment is confidential. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my Provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my Provider believes I would be better served by another form of health care services (e.g., face-to-face services) I will be referred to a health care provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite the efforts of my Provider, my condition may not completely improve.

Therefore, I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I HAVE NO OTHER PRE-EXISTING MEDICAL CONDITIONS THAT HAVE NOT ALREADY BEEN DISCLOSED HERE. I understand that this visit/encounter does not and should not replace a traditional office visit; and therefore, I am proceeding with this tele-evaluation with this understanding. I also understand that should my condition or my responsible parties be an emergency, I should contact local emergency response by dialing 911. I certify that the information provided in this form is true and accurate to the best of my ability. I also understand that omitting medical information or misinforming a Range of Motion Chiropractic provider may result in an inaccurate diagnosis and treatment. I have read and understand the information provided above. I have discussed it with a Range of Motion Chiropractic provider, and all of my questions have been answered to my satisfaction.

Print Name	Signature	Date

Range of Motion Chiropractic
2850 Artesia Blvd. Ste. 201
Redondo Beach, CA. 90278
310.978.7807
www.rangeofmotionchiro.com
info@rangeofmotionchiro.com