**CONSENT TO TREAT AND TELEMEDICINE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request and consent to Palm Beach Wellness Institute to perform all clinical services and wellness services deemed necessary in the evaluation of program/client appropriateness. I acknowledge and understand that no promises or guarantees have been made to me regarding the outcome of my treatment plan by Palm Beach Wellness Institute and I do hereby release Palm Beach Wellness Institute from any liability in the event my treatment is unsuccessful, either in the short or long term.

I have been advised and understand that I will be under the care of the managing physician, or the physician assigned by Palm Beach Wellness Institute, and I give consent to all examinations, laboratory procedures, psychological testing, and other such similar procedures. Medical treatment shall be rendered under the order of the managing physician, or her designee.

In case of severe medical emergency, I have listed an emergency medical contact on a release form and do authorize Palm Beach Wellness Institute to contact that party should such an emergency occur. Further, I understand that, while under the care of Palm Beach Wellness Institute, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate by my managing physician, their providers, and designees, I consent to such emergency treatment and/or transfer to a hospital and indemnify, and hold harmless, Palm Beach Wellness Institute, its staff, or any physician who may be in attendance from any loss resulting from such emergency treatment and/or transfer.

I understand that Palm Beach Wellness Institute will not be responsible for any unknown medical conditions that may arise during treatment, even if they lead to sudden death, coma, or serious medical complications, and for which Palm Beach Wellness Institute shall be released from any liability thereon. I represent that I have fully discussed all of my medical conditions and all medications that I am taking with Palm Beach Wellness Institute and/or its contractors.

I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located.

I understand that the institution is based in Florida and likewise uses telemedicine to conduct consultation with their patients.

I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication.

I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine.

I understand that I will be responsible for any payments 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 have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent.

I understand any lawsuit arising out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.

**With the pronouncements above:**

I authorize Palm Beach Wellness Institute to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine.

Whenever necessary, I authorize Palm Beach Wellness Institute to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

**Approved and agreed to** this (Date) \_\_\_\_\_\_\_\_\_ by the undersigned:

Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signer is not the Patient,

Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_