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**Health For Life Clinic, Inc.**  
**112 N Cornell Ave. Lancaster, PA 17603**  
**Phone (717) 669-1050 Fax (717) 397-4543**

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**INFORMED CONSENT FOR TELEHEALTH**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the naturopathic consultant and licensed acupuncturist of Health For Life Clinic, Inc. to engage in telehealth consultations:

- **I understand that virtual technology will not be the same as a direct healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider**
- **I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult if it is felt that the connections are not adequate for the situation**
- **I understand that I may omit specific details of my medical history that are personally sensitive to me, and can terminate the consultation at any time**
- **I have reviewed the alternatives to telehealth consultation available to me at [www.doctornaturalmedicine.com](http://www.doctornaturalmedicine.com), and am choosing to participate in a telehealth consultation.**
- **In any emergent conditions, I understand that it is my responsibility to seek local in-person care as needed, at the conclusion of the telehealth consultation.**

I recognize the potential risks and benefits of the procedures I am receiving, as described more generally below:

**Potential risks:** interruptions in technology, unauthorized access and technical difficulties, incomplete care that requires in-person visits with a healthcare provider. Allergic reactions and/or side effects to supplements, inconvenience of lifestyle changes, aggravation of present conditions, and possible drug interactions with natural supplements or products. I will not hold Ann Lee, ND, L.Ac, responsible or liable should I have such reactions. and aggravation of present conditions.

**Potential benefits and purpose:** receive health recommendations from comfort of home, not requiring any travel, especially if need to follow physical distancing for public health purposes.

**Notice to Pregnant Women:** All female clients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the practitioner regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I consent to additional procedures from those described herein that are deemed necessary.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy by paying the appropriate copying fee.

I understand that my medical record will be kept for a maximum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I understand that Ann Lee is a naturopathic consultant and acupuncturist, not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check ups. I further understand that Ann Lee does not diagnose, treat or prescribe for any particular symptom, disease or condition, including cancer. I understand that she will work on increasing my general vitality and constitutional strength, providing supportive care to feel as good as possible for as long as possible.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

If the client is a minor or is unable to consent, please complete the following: Age \_\_\_\_\_

Name of Guardian \_\_\_\_\_ Relationship \_\_\_\_\_ Signature \_\_\_\_\_