Dr. Jessica Greene, ND, DC

928 Fort Stockton Drive Ste 213

San Diego, CA 92103

858-255-0499

**Informed Consent for Telehealth Naturopathic Treatment**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Dr. Jessica Greene, ND, DC to perform diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as Telehealth. I understand that I will not be seeing her/him in an office setting and that she/he will not be my primary care provider and I must maintain a primary care provider for physical examinations and other diagnostic and screening procedures. I understand that I must be present in the state of CA when communicating with the doctor.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes and aggravation of present conditions.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest.

I have had the opportunity to ask questions and discuss with Dr. Greene:

1) my suspected diagnosis or condition

2) the nature, purpose and potential benefit of the proposed care

3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure

4) the probability or likelihood of success

5) reasonable available alternatives to the proposed treatment / procedure

6) the possible consequences if treatment or advice is not followed and/or nothing done.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Dr. Jessica Greene, ND, DC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

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 Signature of patient Date