

HUTTO WELLNESS  
407 Walnut Street  
Green Cove Springs, FL 32043  
904-863-3275, [contact@huttowellness.com](mailto:contact@huttowellness.com)

❖ CONSENT FOR TELEHEALTH CONSULTATION (Initial and Follow Up Consultations)

1. I understand that I am voluntarily engaging in a telemedicine consultation done by a with (HUTTO WELLNESS). I understand that I am disclosing basic medical history, current symptoms (if any), and goals for treatment that will be reviewed by a licensed medical provider. The medical provider will then approve the desired medical interventions and/or prescriptions being requested after reviewing your submitted information. Your request will be approved pending any contraindications to therapy.
2. I understand that additional health information may be submitted to the medical provider through our HIPPA complaint website [contact@huttowellness.com](mailto:contact@huttowellness.com). The evaluation will be limited not be in the same room as my health care provider. I understand that this is a convenience and a courtesy provided by (HUTTO WELLNESS).
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation (if done via video or phone) that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to schedule an office visit or to forgo evaluation and treatment with (HUTTO WELLNESS) and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation via video or telephone.
7. I understand that telemedicine has limitations regarding the physical examination. I understand that the physical exam portion with (HUTTO WELLNESS) will not done.
8. Telemedicine services offered through (HUTTO WELLNESS) are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.

By accepting telehealth communication, I certify: That I understand the risks and benefits of telemedicine.

- That I have had the opportunity to ask questions by telephone or video and if desired by emailing (HUTTO WELLNESS) at [contact@huttowellness.com](mailto:contact@huttowellness.com), and have had my questions answered to my satisfaction before submitting the requested information.
- **Disclosure:** in compliance with FL Satute 464.0123 (7)
- **64B9-4.001 Definitions.** (12) Primary care practice – includes physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions.
- **64B9-4.021 Standards for Autonomous Practice.** Advanced practice registered nurses who are registered pursuant to Section 464.0123, F.S., shall engage in autonomous practice only in a manner that meets the General Standard of Practice. The General Standard of Practice shall be that standard of practice, care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similarly situated, educated, and licensed Advanced Practice Registered Nurses.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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