Su Fairchild MD / Alliance Integrative Medicine LLC
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Telemedicine and Communication Consent

As this is a telemedine practice, appointments are usually made by email and conducted using phone or video. Messaging apps are also offered for convenience.

Although encrypted email is used, and computers, associated devices, and apps or programs are protected by passwords, all these methods of communication have inherent confidentiality risks, may not be fully secure, and may not meet the security requirements set forth by the Health Insurance Portability and Accountability Act (HIPAA).

Encrypted email: doctor@allianceintegrative.com
Video : https://doxy.me/aim
Messaging via app or computer : www.pushhealth.com (use code SFAIRCHILD)
Messaging via app or computer : www.medtunnel.com (use ID : doc@iAim)
Electronic Medical Records : https://sfairchild4485.patientlogon.com/ (let me know if you want direct access)

Secure video or phone is used for appointments (depending on State regulations). Due to the nature of video communications, interruptions may occur. Should this occur, attempts will be made to fall back to phone.

____ *(initial) I, the undersigned, have read and understood the above, and consent to electronic communication and understand that even communications considered secure may sometimes be breached.*

____ *(initial) I release Dr Fairchild and Alliance Integrative Medicine LLC from any and all liability that may arise from use of secure and non-secure communication, and video or phone telemedicine.*

____ *(initial) I agree to hold harmless Dr Fairchild and Alliance Integrative Medicine for any information that may be lost due to any technical failure.*

____ *(initial) Because telemedicine has some limitations, I agree that Dr Fairchild makes the final determination if a condition is not suitable for telemedicine management.*

____ *(initial) Because telemedicine is not full-service, I agree to maintain, as my main doctor, an in-person Primary Care Provider I see for routine and other care.*

Document preferences (choose only one)
Documents include lab results, lab orders, and other forms containing personal health information.
___ I wish for documents to be delivered to me by Encrypted Email attachment where possible.
___ I wish for documents to be faxed to me. (You must have a private fax. Output will be black and white)

Only initial if someone other than yourself is also communicating with Dr Fairchild on your behalf:

____ (initial) I authorize _____ to communicate with Dr Fairchild about my personal health on my behalf, and to represent my wishes regarding my care.

Billing:

____ (initial) I authorize invoices to be sent via SquareUp to my email address on file for credit card payment, however, I understand I also have the option to pay by check.

Signature:_____

Name:_____ Date:_____