Telehealth Informed Consent

Laura Chasteen, RDN (Laura Chasteen Nutrition, LLC)
Virtual Medical Nutrition Therapy and Nutrition Counseling
Washington State
Effective January 1, 2026

Client Information

- **Patient or Client Full Name:**
- **Patient or Client Date of Birth:**
- **Guarantor Full Name (if applicable):**
- **Guarantor Date of Birth (if applicable):**

Consent for Telehealth Services

I voluntarily consent to receive Medical Nutrition Therapy and nutrition counseling services via **telehealth** from Laura Chasteen, RDN via Laura Chasteen Nutrition, LLC.

I understand and acknowledge the following:

1. **The Nature of Telehealth**
   Telehealth involves the delivery of healthcare services using electronic communication technology, including video and/or audio conferencing, when the provider and client are in different locations.
2. **Licensure & Location**
   I confirm that I will be physically located in **Washington State** at the time of each telehealth session and understand that services may not be provided if I am located outside the provider's licensed jurisdiction.
3. **Potential Risks & Limitations**
   I understand that telehealth services may involve:
   - Technical difficulties or interruptions
   - Limitations compared to in-person services
   - Risks to confidentiality due to factors outside the Practice's control
4. **Privacy & HIPAA**
   - Telehealth services are provided using HIPAA-compliant platforms.
   - I am responsible for participating from a private, secure location and safeguarding my own privacy during sessions.

    - The Practice complies with HIPAA and Washington State privacy laws.
5. **Emergency Situations**
   I understand that telehealth is not appropriate for emergency situations. In an emergency, I agree to call 911 or seek care at the nearest emergency facility.
6. **Right to Withdraw Consent**
   I understand that I may withdraw my consent for telehealth services at any time by providing written notice (via e-mail to laura@laurachasteennutrition.com), recognizing that withdrawal may affect my ability to receive services.
7. **Consent to Treatment**
   I consent to receive Medical Nutrition Therapy and related services via telehealth and understand that telehealth services may be discontinued if deemed clinically inappropriate.

Acknowledgment & Signature

I have read and understand the information above and voluntarily consent to participate in telehealth services.

Patient or Client Signature:

Guarantor Signature if Applicable:

Patient or Client Printed Name:

Guarantor Signature if Applicable:

Date: