Restorative Health Clinic

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Consent for Assessment and Treatment

I understand as a patient of Restorative Health Clinic that my preliminary diagnosis and treatments will be discussed and determined with one of our Doctors.

I understand that I have the right, as a patient, to be informed about my condition and the recommendations for testing and treating be they conventional, integrative, complementary, alternative, non-conventional or non standard. My informed decision whether or not to undergo testing or treatment will be made after I have been informed of all the potential benefits and risks involved.

I understand that some of the treatments recommended by my Doctor do not fall under the general definition of conventional medicine. My treatments may include both conventional and natural medicine techniques such as IV therapy, injection therapy, homeopathy, naturopathy, supplements and conventional prescriptions.

Before I consent to recommended treatments I will have a practitioner explain all the procedures, alternatives, benefits and risks.

Typically, treatment is provided over the course of several weeks, or months. In an effort to give you the most effective treatment possible it is important to follow thru with your appointments and course of treatments in the manner prescribed by my Doctor.

Except for emergencies, procedures are not performed until you have had an opportunity to discuss any questions and concerns.

Consent for evaluation and treatment is hereby given under the terms described in this consent document. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

I understand that all information shared with the physicians, therapists and staff of Restorative Health Clinic is confidential and no information will be released without my written consent.

I do hereby indemnify and hold harmless the physicians, therapists, clinic and staff of Restorative Health Clinic who act in reliance upon this authorization.

Patient Name (Please Print) _____Date_____

Patient Signature _____