Natural Medicine Clinic, LLC
P.O. Box 825
Fairforest, SC 29336
(864)708-2567

Informed Consent for Treatment

I hereby request and consent to the performance of diagnostic and treatment procedures performed by, or recommended, and/or referred by Natural Medicine Clinic, LLC. These may include, but are not limited to, various diagnostic procedures such as x-rays, neurodiagnostic studies, electrodermal testing, Doppler ultrasound, digital pulse analysis, heart variability analysis, oxymetry, spirometry, laboratory testing (such as hair biopsy, blood chemistries and other analyses of bodily tissues and substances); various modes of manipulative treatments and physiotherapeutics; various natural medicines, nutritional and supplement recommendations, or any other treatments prescribed, on, by, or for me (or on, by, or for the patient named below, for whom I am legally responsible) by the physicians and staff of this facility who now or in the future will render care to me (or the patient named below) while employed by, working, or associated with, Natural Medicine Clinic, LLC, or those who may serve as back-up for this facility, or any other office or clinic associated with Natural Medicine Clinic, LLC.

I have had the opportunity to discuss with the physician(s) and/or staff of this facility regarding the nature and purpose of the above procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all health care, there are some risks to diagnostic and treatment procedures, including, but not limited to, fractures, disc injuries, strokes, dislocations, strains, and sprains. I do not expect the doctor (or staff) to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor (and/or staff) to exercise judgment during the course of the procedure which the healthcare provider feels at the time, based upon the facts then known, is in my best interest. Alternative treatments may include, but are not limited to: natural medicines and supplements, dietary therapy, metabolic/nutritional therapy, trigger point therapy, laser treatments, LED treatments, exercise therapy, vibration therapy, emotional reinforcement techniques, behavioral modification, acupressure, neurological or brain-based therapy, manipulative or physiotherapeutic procedures. As with any of these alternative procedures there are risks. If not treatment is sought, I understand that my condition could get worse, remain the same, or improve.

I also certify that I am seeking care through this facility for my specific health condition(s), and for no other reason.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and treatment. I intend this consent form to cover the entire course of treatment for my care in this office.

____
Patient's Signature Date

____
Doctor's Signature Date

To be completed by patient's representative, if patient is a minor or is physically or mentally incapacitated.

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Name of Patient

____
Signature of Patient's Representative

____
Relationship to Patient