FUNCTIONAL MEDICINE INFORMED CONSENT

Regarding Treatment and Care

I hereby request nutritional consultations and functional medicine treatment. I understand that in the practice of functional medicine some treatments are considered "alternative" by the conventional medical community and that there are some risks to treatment. I do not expect the Doctor to be able to anticipate and explain *all* the risks and complications and I wish to rely on the Doctor to exercise judgment during the course of treatment based upon the facts then known and in my best interest.

Regarding Diet Recommendations and Nutritional /Herbal Supplements

We may make diet recommendations and recommendations regarding use of nutritional and herbal supplements in order to supply nutrition to support the physiological and biomechanical processes of the human body. Although these foods and products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

As a service to you, we make nutritional supplements available in our office. We purchase only top quality products and only from manufacturers who have gained our confidence through considerable research and experience. You are under no obligation to purchase these in our office but we cannot guarantee a similar quality from an outside source. Refunds will be given to any supplement that is unopened and returned within 14 days of purchase.

Regarding Privacy Practices and E-mail Correspondence

The Health Insurance Portability and Accountability Act (HIPAA) requires us to let you know how your Patient Health Information (PHI) is going to be used and your rights concerning those records. I agree to allow this office to use my PHI for the purpose of treatment and coordination of care. I have the right to examine and obtain a copy of my health records and request corrections. I can request to know what disclosures have been made and submit any future restrictions. All staff will take precautions to assure my records are not available to those who do not need them. I also authorize correspondence deemed appropriate by the doctor to be sent to me by e-mail.

I have read and understand the **Treatment and Care Consent,** the **Diet Recommendations and Nutritional/ Herbal Supplements Consent,** and the **Privacy Practices and E-mail Correspondence.**

X_____ _____

Signature **Date**