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Cedar Avenue
INTEGRATIVE MEDICINE

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Consent for Treatment

I, the undersigned, hereby authorize the physicians listed above to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures, which may include but is not limited to venipuncture, PAP smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and non-drug contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

Soft Tissue and Osseous Manipulation: use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine, including traction.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: Dressing wounds, ear cleansing, care of superficial lacerations.

Electromagnetic and Thermal Therapies: The use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, and hydrotherapy.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Discomfort, pain, minor bruising, infection, blistering, loss of consciousness or deep tissue injury from, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the

strengthening of the constitution, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of her ability.

_____	_____
Patient's Name (Print)	Guardian's Name (Print)
_____	_____
Patient's Signature	Guardian's Signature
_____	_____ _____
Date	Relationship to Patient Date