TRUE HEALTH INTEGRATIVE MEDICAL CENTER

DECLARATION AND CONSENT TO TREAT (Child)

Payment

We require payment at the time of your visit for services rendered. We accept check, major credit cards, and cash, however we **do not offer change**. New Patient (child) fees for naturopathic consults are billed at **$295.00** and the duration of the appointment is approximately 90 minutes. We ask that you set aside two hours as some cases can be more complex. Follow-up appointments are billed at **$250/hr.** Dr. Adrienne Wilson does not accept nor bill any insurance, however you may submit to your insurance if Naturopathic Medicine is covered. FaceTime/Skype, phone consults and extended emails will be charged as an in-office visit at the hourly rate.

Appointments

We consider an appointment to be an agreement between you and our office. We are responsible to be here and provide our services, or to inform you otherwise. You are responsible for keeping the appointment or giving us 24 hour's notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, you will be charged a service charge, except in the case of emergency.

Assignment of Benefits

I hereby assign my child's medical benefits for services rendered by Dr. Adrienne Wilson. This assignment will remain in effect until I revoke it in writing. A photocopy or fax of this assignment is to be considered as valid as an original. I authorize Dr. Adrienne Wilson to release all information necessary to secure payment in full. I understand that I am financially responsible for all the charges whether or not paid by an insurance company or attorney.

Treatment

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Fever, headache, low blood calcium, or drop in blood pressure from chelation
- Muscle strains and sprains, disc injures from spinal manipulation.
- The potential for stroke is a concern in neck manipulation. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at the medical record at any time and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from the medical record may be analyzed for research purposes and that patient identity will be protected and kept confidential.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of the procedure which they feel at that time is in my child's best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

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I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future from another licensed health care provider;

I am at liberty to seek or continue medical care from a physician or surgeon or another health care provider qualified to practice in Arizona;

No one under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I, if requested, have received a full and complete explanation of the treatment or services my child may receive by Dr. Adrienne Wilson. I hereby give Dr. Adrienne Wilson permission to examine, diagnose and treat my child.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, administrative fees as well as other applicable fees.

Adrienne Wilson, NMD

_____ _____

Full Patient Name (please print) Naturopathic Doctor

_____ _____

Signature of Parent or Guardian Date of Consent