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General Consent for Treatment and Clinic Policies

I, _____, hereby authorize all qualified medical personnel of Elevated Natural Health Center, PLLC to perform routine and emergency medical exams and procedures as necessary to facilitate my and/or my child's diagnosis and treatment. I can request that students and preceptors not be included in my care or treatment at any time.

I also understand that I have a right to ask questions about and discuss to my satisfaction any exam or treatment that will be performed. I may request more information regarding: my diagnosis; the proposed care plan; any risks, complications, potential hazards, or side effects of a treatment or procedure; the likelihood of success; alternatives to the proposed treatment; and/or any other questions that may arise during or after the visit. I understand that providers at Elevated Natural Health may use alternative analysis and treatment modalities.

I understand that I have the ability and it is my right to be able to select/direct which pharmacy my prescriber uses to fill my medication orders.

Phone Calls: I understand that Elevated Natural Health does not provide after-hours care at this time. While I am welcomed and encouraged to call at any time with any concern, I understand that a provider or staff member may not return my call for a minimum of 12-24 hours. Lastly, if I have a medical emergency, I understand that I should seek care with an emergency department immediately.

Notice to all pregnant women: All pregnant women must inform the provider if they have confirmed or suspected pregnancy as some of the therapies or exams could present a risk in pregnancy.

Notice to patients with implants: All patients with implants including, but not limited to: metal joint replacements, metal bone replacements, defibrillators, pacemakers, breast implants, muscle implants, and any other implant must inform the provider as some therapies or exams may present a risk for certain types of implanted materials.

Notice to patients with bleeding disorders: Please inform your provider of any family history or personal history of bleeding disorders of any sort (genetic, acquired, etc.).

Email Policy: Patients will be charged for email correspondence when seeking health advice for new concerns. Emails will be assessed a fee of $30-$75 based on the complexity of the question(s) and the time it requires to reply and manage the concern. When a provider requests an email to follow up on a treatment or other issue, these emails are not assessed a fee. In addition, you will not be charged for an email that is SOLELY related to clarification of current treatment plans or instructions.

This consent will be in effect until revoked in writing by me. *I certify that I have read, understand, and agree to the above. Please note there may be additional consent forms for you to review/ sign for specific treatments offered.*

_____ _____
Patient's Printed name Legal Guardian/Parent's Printed Name

_____ _____
Signature Date