HEALTHY KIDS PEDIATRICS

Authorization and Consent for Testing & Medical Care Including the Use of Alternative, Complementary & Integrative Methods

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

This document is a binding contract setting forth the obligations I assume in consideration for the medical care and treatment to be provided to my child. I, as the parent of the patient and speaking on behalf of my child, agree to be bound by its terms.

FREE WILL: I am here of my own free will, representing no official agency or other organization, voluntarily requesting services for me and/or my dependents. I understand that all requests for information by official agencies or other organizations must be done in writing.

NOTICE IS HEREBY GIVEN THAT PERMISSION IS NOT GRANTED TO INDIVIDUALS WORKING IN AN OFFICIAL (E.G. GOVERNMENT) CAPACITY SEEKING INFORMATION WITHOUT THE WRITTEN CONSENT OF THE LEGAL COUNSEL REPRESENTING THE HEALTHCARE PROVIDERS AT HEALTHY KIDS PEDIATRICS.

INTRODUCTION: I understand that medicine is not an exact science and therefore reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the care provided by Healthy Kids Pediatrics.

Good Medical practice dictates that patients must be informed of certain risks prior to receiving medical care or undergoing medical procedures. This information is given so that I will have the knowledge necessary to make a decision to give or withhold consent for treatment. By signing this form, I voluntarily consent to and authorize the medical procedures noted below.

I acknowledge that additional care and treatment may be required in the future. I further acknowledge that the outcome of medical treatment may be dependent upon my compliance with the instructions of my physician.

RIGHT OF CHOICE: I have been fully informed that there are different schools of medical theory and that medicine is an evolving science. I am aware that in this evolving science, doctors sometimes differ on their approaches to diagnosis or treatment of illness or problems. I have had the opportunity to consider different approaches or schools of medical thought and ask questions of my physician. I understand that I have the right to accept or refuse medical care, based upon my personal judgment.

STANDARDS OF CARE: I have sought out my physician because I know that he/she is willing to use both conventional and unconventional methods depending on the situation. (If I am going to undergo any procedures and/or treatment that are part of a clinical investigation, I will have to sign a separate consent form specifically for the investigation.)
I am aware that alternative medicine is not accepted by some allopathic physicians and that an allopathic physician may reach a diagnosis and provide treatment based upon a different theory. Some allopathic physicians believe that some alternative medicine is not a useful method of treating or helping people. However the standards of allopathic medicine do not apply to the method of diagnosis and treatment which I am requesting.
I am requesting a different approach to health care from traditional allopathic approaches, and the treatment noted below may proceed upon a different set of beliefs from those used by traditional allopathic physicians and/or approved by the American Medical Association. I wish my physician to be guided first by the principle of “do no harm to the patient” and then by his school of medicine plus the adjunctive care which he feels may benefit me or at least help to deal with my problem(s). I agree that now and in the future, that I will not seek to apply the traditional allopathic standards to the medical care and treatment provided by my physician.

HEALTHY KIDS PEDIATRICS

Authorization and Consent for Testing & Medical Care Including the Use of Alternative, Complementary & Integrative Methods

COMPLICATIONS AND UNEXPECTED ADVERSE EFFECTS: I acknowledge that in any medical procedure or treatment that there are certain complications reported in medical journals and/or studies that are due to the procedure or treatment and unexpected adverse effects that may result. As part of the consideration I am giving to my physician in turn for treating me, I make a binding promise to notify the physician if I believe that I am suffering from any unexpected adverse effect, regardless of whose fault the adverse effect may be. Because my physician intends to inform other physicians about unexpected adverse effects, I will notify my physician whether or not it is related to the diagnosis and/or treatment provided by my physician. If I fail to notify my physician within a reasonable time of the onset of such unexpected adverse effect, I agree that any claim that I may have resulting from such adverse effect will be barred, waived and released. I further make a binding promise to notify the physician if I believe that I am suffering from any complication.

AUTHORIZATION: I have read the above or it has been explained to me. I have had the opportunity to ask my physician questions about the treatment which I am consenting to receive, alternative forms of treatment, the risk of non-treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered. I believe that I have sufficient information to give consent to treatment.

In reaching this decision, I have not been promised or guaranteed by anyone, including my physician, that such treatment will be effective in my particular case, or, if effective, more effective than any other treatment I may be undergoing or have undergone or which may exist for the treatment of my complaints.

I desire the following testing and/or treatments:

- ☐ Nutritional Support
- ☐ Allergy Control
- ☐ Detoxification Support
- ☐ Selective Vaccination Schedule

The specific risks and complications reported in medical literature about this type of procedure/treatment have been explained to me. **I acknowledge that the risks and complications are as follows:**
Possibility of no benefits.
Possible reactions to medications, homeopathies, botanicals and/or supplements, or contracting a vaccine preventable disease.

I acknowledge that I have voluntarily accepted the risk of the complications noted herein and state that I will not have any claim if I suffer from said complications.

I realize that I may at any time, refuse to consent to a continuation of treatment or revoke this consent. In doing so, I may be requested to sign a form acknowledging this decision. However, if I decide to revoke my consent to treatment, it shall remain applicable for any treatment and procedures rendered prior to any such revocation.

I have read the above or it has been explained to me.

Signature	Date
Witness' Signature	Date
Physician Signature	Date

I certify that I have received a copy of this signed request form.

Patient/Parent's Signature	Date

Print Form

Rev 11/2014