

Alternative Medicine Consent and Financial Agreement

Please read this document carefully. This agreement outlines the consent for alternative medicine treatments and the financial policies of our practice. After reviewing, please fill out the required fields below for printing and signing.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Street Address:

2. Informed Consent for Alternative Medicine

I hereby request and consent to receive alternative medicine treatments, which may include but are not limited to acupuncture, herbal medicine, nutritional counseling, aromatherapy, and holistic lifestyle coaching.

Potential Benefits: Relief of symptoms, improved health, stress reduction, and overall wellness.

Potential Risks: While these therapies are generally safe, some risks may include mild bruising, temporary soreness, fatigue, or allergic reactions to herbal supplements.

Voluntary Participation: I understand that alternative therapies are voluntary, and I have the right to decline or discontinue treatment at any time.

Please initial to acknowledge consent:

3. Financial Agreement

By signing below, I agree to the following financial policies:

- **Payment of Services:** Payment is due in full at the time of service.
- **Insurance Disclaimer:** I understand that alternative medicine therapies may not be covered by standard health insurance policies. I accept full personal responsibility for all charges incurred.
- **Cancellation Policy:** A minimum of 24 hours notice is required for cancellations. Failure to do so may result in a late cancellation fee.

Please initial to acknowledge financial agreement:

4. Acknowledgment and Signature

By signing, I certify that I have read, understood, and agree to the Consent for Treatment and the Financial Agreement outlined above.

Patient Signature (Print Name):

Date (MM/DD/YYYY):

Provider/Witness Signature (Print Name):

Date (MM/DD/YYYY):