Dr. Rickert Total Health Client Paperwork

Please initial each paragraph after reading.

Important Notes

_____ **Dr. Ann E. Rickert, MD** is not your primary physician. She is functioning as a health consultant. She does not take care of medical emergencies. **If you have a medical emergency you must contact your primary care physician or call 911.**

_____ Insurance **Free Practice** I am able to give you a bill that may qualify under your health savings account. Payment is due on the day of service and can be paid by check or credit card.

Consult Disclaimer and Informed Consent

_____ Informed consent is the process by which a fully informed person can participate in choices about his or her health. This consent form is intended to provide you with information about my practice, the nature of decisions regarding your health, reasonable alternatives to the proposed process, the relevant risks, benefits and uncertainties related to the alternatives, an assessment of your understanding, and your acceptance of the process. This is an invitation for you to participate in your decisions.

Nature of Relationship

_____ I am functioning as a health consultant. My services are not meant to be a substitute for, or replace those of, your primary care physician. I advise that you be under the care of a licensed physician and I encourage open communication between your current physician and me. I do not handle medical emergencies of any kind and refer clients with such emergencies to 911 or the emergency room of their local hospital.

_____ We will discuss the proposed ideas with you before we initiate any action only after I receive your assurance that you understand the situation, understand the risks associated with the decision at hand and you communicate a decision to proceed based on your understanding. We will also advise you of any significant risk, which could affect the judgement of a reasonable patient. You always have the right to refuse any proposed ideas entirely or to certain parts of your body.

______You agree to advise us regarding me regarding your medications, drugs, and aspects of your underlying disease and state of mind that may affect your capacity to make an informed decision. You also agree to advise me if you have ever experienced a seizure or fainting, if you have a pacemaker, a bleeding disorder, are

taking anticoagulants, or if you have damaged heart valves or have any increased risk of infection.

_____ If you are determined to be incapacitated or incompetent to make decisions regarding your health, you agree to provide information regarding a surrogate decision maker who can legally speak for you.

Risk of Self Treatment

_____ Potential risks of self-treatment include allergic reactions, sensitivities, and adverse effects to natural supplements and adjustments to making lifestyle modifications. Although this consent from describes major risks of treatment, other side effects and risks may occur.

Your Responsibilities

_____ You agree that if you have a complaint, you will talk to me about it. If we are unable to resolve it informally, we agree to binding arbitration in Boston, MA under the rules of the American Arbitration Association. Reasonable discovery shall be permitted and the prevailing party be entitled to attorney's fees and costs of the arbitration.

_____ You agree to take full responsibility for taking any natural remedy that we suggest and you agree that we am not liable for any adverse effects or complications from such natural remedies. You agree to cease taking all natural remedies upon the onset of adverse effects. You understand that the supplements and herbs need to be consumed according to the instructions provided orally or in writing. Some supplements and herbs may have a taste or a smell. You agree to immediately notify me of any unanticipated or unpleasant effects associated with the consumption of the supplements of herbs. You will also notify us if you are or become pregnant or are nursing as some supplements and herbs may be inappropriate during pregnancy and/or nursing. You do not expect that we will be able to anticipate and explain all possible risks and complications of treatment and you understand that the results are not guaranteed.

Consent

_____ By voluntarily signing below you show that you have read or had read to you, this consent to treatment, have been told about the risks and benefits or nutritional and lifestyle consulting, and have had an opportunity to ask questions. You intend this consent form to cover the entire course of treatment for your present condition and for any future conditions from which you seek treatment.

_____ Even if you provide personal health information to us in the course of consultation, it is not intended as a substitute for a physical exam and face-to-face consultation with your personal physician.

_____ All matters regarding your health require medical supervision by healthcare professionals selected by you. You and your personal healthcare providers shall have executive authority and control over your health and healthcare, including diagnosis, treatment, and other determinations related thereto, and nothing discussed in a consultation between us is intended to or shall influence, restrict, or interfere with your personal healthcare professionals' exercise of independent clinical, medical, or professional judgement in providing healthcare services to you.

_____ As such, we shall not be liable or responsible for, and you hereby release us from, any loss or damage allegedly arising from any information or suggestions made during any consultation between us.

______________________________________ __________________

Printed name Date
Executed

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Signature