Wholeness Center

Tax ID# 83-1344190
Office: (970) 221-1106
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2620 E Prospect Rd., Suite 190
Fort Collins, CO 80525

Consent to Care

Patient's Name: _____ Date of Birth _____

Today's date _____

I voluntarily consent to outpatient care at Wholeness Health, encompassing routine diagnostic procedures and examination. I understand Wholeness Health LLC uses an integrative psychiatry and mental health approach and provides naturopathic, nutritional and supplement consulting as a part of the recommendations/suggestions provided to the patient by the care provider. Wholeness Health LLC's consulting is not intended as a diagnosis, treatment, prescription, or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care.

I understand that the care I receive from Wholeness Health LLC may be nontraditional or non---conventional. Such services are commonly referred to as integrative, or complementary/alternative medicine (CAM), or holistic services. This can include acupuncture, naturopathy, nutritional, herbal consultation, homeopathy and mind---body approaches to care as well as non--- conventional medical therapies. Many of these services may not be recognized as standard of care, and while many have long been practiced, may still be considered investigative or experimental. I understand that I will discuss potential therapies with my practitioner that he/she recommends, and that I agree to accept the risks explained to me about these procedures by agreeing to accept these treatments.

I understand that Scott Shannon, M.D., Craig Heacock M.D., Brooke Schneider D.O.&, Naveen Thomas, M.D. are licensed medical doctors, and that the other Wholeness Health LLC professionals are licensed in their respective professions and that they will evaluate and advise me from the perspective of their training. I understand that none of these approaches should replace needed medical care and my work with primary care or other physicians as needed.

Wholeness Health LLC is not responsible for any negative or adverse reaction to any medication currently prescribed to the patient as a result of any supplement or course of nutrition suggested, nor as a result of any prescription given after the counseling by Wholeness Health LLC. We will make every effort to reduce risks and manage current psychiatric medications.

Consultations may include discussion of diet, dietary supplements, herbal or botanical products. While herbs and botanical products are generally available over---the---counter and considered safe based upon research and their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let my physician know what herbs and medications I am taking.

It is understood that some or all of the supplements that may be suggested through counseling may not be approved by the United States Food and Drug Administration (USFDA). Additionally, some labs may be used that are not USFDA approved, and Wholeness Health may use some research based labs.

Some of the Wholeness Health practitioners use an array of methods that may be known as mind/body medicine as well as psychotherapy, which are intended to assess my well---being such as improving my lifestyle, capacity to function in a meaningful and effective way, or assisting me in resolving traumatic experiences. I understand that because stress and emotional states play a role in medical conditions, my practitioner may suggest mind/body approaches such as meditation, massage, or other stress management techniques as well as psychotherapy or hypnosis. I understand that this is not an exact science and is not fully demonstrated as having value.

I have read and understand the foregoing and that I will have an opportunity to discuss any concerns I have about treatment with my practitioners. I understand the nature of these health care methods, and agree to counseling or treatment.

Signature of Patient: _____

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If the patient is a minor or is unable to consent, please complete the following:

- Patient is a minor and is _____ years of age.
- Name of Father _____ Name of Mother _____
- Patient is unable to consent because _____

_____ _____ _____

Signature of both Parents/Relatives/ Legal Guardian | Please Print Name | Relationship

_____ _____ _____

Signature of both Parents/Relatives/ Legal Guardian | Please Print Name | Relationship