INFORMED CONSENT TO CONSULTATION AND TREATMENT

Please read, carefully, the following:

1. The consultants of the Lexington Natural Health Center are specialists in naturopathic medicine. They are not primary care physicians, board certified oncologists, MD's nor immunologists. They are licensed ND's, naturopathic doctors. For more information on naturopathic doctors please visit http://www.lexingtonnaturalhealth.com/pages/Information.html
2. The Lexington Natural Health Center provides consultative services to people who have been diagnosed with cancer, as well as to the family members or close personal friends of those people who have been diagnosed with cancer under the following circumstances, that:
    a. the consultee(s) understand(s) that the consultants of the Lexington Natural Health Center (herein referred to as LNHC) cannot manage the overall care of the person with cancer for whom the consultation is occurring;

    b. the consultee(s) understand(s) that the treatment suggestion provided by LNHC are not all accepted by the United States FDA and therefore should not be taken as such;

    c. the consultee(s) understand(s) that the treatment suggestions provided by the LNHC are not intended to replace those treatments prescribed by the physician managing the case overall;

    d. the consultee(s) understand(s) the consultants of LNHC may suggest changes to the therapeutic plan for the person with cancer for whom the consultation is occurring, within the scope of their licensure;

    e. the consultee(s) understand(s) that it is important to make the managing physician aware of any additions or changes to the treatment plan for the person with cancer for whom the consultation is occurring; and that

    f. the consultee(s) understand LNHC is not a provider for Medicare, Medicaid nor any other insurance carrier and therefore the services rendered by LNHC are not covered by any insurance plan.

By signing below, I, _____, have read and understood the above criteria and give my full consent to a consultation from LNHC.

Signature _____Date_____

Printed Name _____

Signature of Patient Representative or Guardian _____

Printed Name _____ Date _____

Doctor Signature _____

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