

## Patient Consent to Services Form

I voluntarily consent for (please initial all that apply):  herbal consultation  reiki treatment  fitness consultation  nutrition consultation

Name of Client \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

### Herbal Consultations

I understand that herbs are considered to be food supplements and are utilized to strengthen and support overall health and wellness. Herbs along with nonmedical suggestions can serve as an excellent adjunct to a medical doctor's treatment, but are not a substitute for that treatment. An herbalist can neither diagnose nor treat disease.

### Risks/Possible side effects/Healing response

The historical record and modern research indicate that the herbs most often used for healthcare have an exceptional safety record. However, adverse events can occur after using any active substance. Side effects that have occasionally been reported after using herbs include headaches, skin rashes and digestive upsets. Such effects generally resolve rapidly, especially if the dosage is reduced or the herb is stopped. Allergic reactions are also very rare but have been reported, usually in individuals with contact allergy to specific plants. Should an adverse reaction occur, I agree to immediately contact my herbalist. My herbalist may be able to propose measures to reduce any discomforts or may refer me to a physician.

### Herb-drug interaction

Although speculative interactions between herbs and drugs are sometimes publicized, confirmed cases are rare. Nevertheless, some prescribed drugs are very strong and have a narrow range of safe dosage, which makes any interaction more risky. It is the responsibility of the clients to disclose fully any medications currently in use, including other herbs and supplements, so that they can be offered informed advice. Clients also are expected to inform their physicians of any herbs or supplements they are using. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb should be reported directly to all health professionals involved. It is also advisable to stop taking herbs at least 48 hours before surgical operation, and in the event of prescribed anticoagulants, antiepileptic drugs, and digoxin until expert advice is received.

### Toxicity

We will not expose clients to plant doses known to have toxic effects. The organs that are most vulnerable to any potent substances are the liver and kidneys, and it will be important for the client to divulge any previous history of disease in either of these organs. Herbs should not be used in pregnancy and lactation without expert advice, and clients who become pregnant should stop taking herbs until advice is received.

### Exercise/Fitness

I understand that the fitness instruction I receive is for the basic purpose of moving and strengthening the muscles, joints, ligaments and bones in the body.

**Risks**

I understand that I may experience pain or discomfort from exercising. If I do experience pain or discomfort during the session, I will immediately inform my exercise coach so that the exercise may be adjusted. I will not hold them responsible for any pain, discomfort, injury or reaction I may experience as a result of performing an exercise.

**No Guarantees**

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

**Infectious Disease Prevention**

I understand that infectious diseases are carried through the air, through physical contact, and through bodily fluids. I understand that this wellness company follows universally prescribed precautions and procedures to prevent the spread of infectious disease.

**Client Responsibilities**

I understand that it is my responsibility as a client to inform my practitioner of all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. I will inform my practitioner if I am pregnant and/or suspect pregnancy at any time. If I experience pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

**Medical Treatment**

I recognize that Lucca Amel Wellness is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering my medications or medical treatments. I understand that I am free to consult my medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

**License or Certification**

I understand that that State of Maryland does not license herbal practitioners and that any statement of credentials is for information purposes only.

**Fees and Charges**

I have been informed of the fees for services, and I understand that payment is due when the services are provided. If I do not cancel an appointment at least 24 hours in advance then I am liable for the fee.

I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service(s) to be performed have been explained to me. I have also received the Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information. I understand my health information will be used and disclosed consistent with this Notice, and that I have felt free to ask my practitioner questions regarding the proposed services, this consent form, and other pertinent information, including questions about him or her, and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

To be signed and witnessed before services are provided.

Signature of Client\_\_\_\_\_

Date\_\_\_\_\_

Signature of Practitioner\_\_\_\_\_

Date\_\_\_\_\_