

# Consent Form

**PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.**

## Consent To Treatment

Naturopathic, homeopathic, and Chinese medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

Naturopathic, homeopathic nor Oriental medicine are regulated by the state of Alabama. I understand that my practitioner has a national license but no professional license issues by the state of Alabama to practice medicine as it is not regulated by the state legislature.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

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Print Name

Signature of Patient

Date

## Agreement to Payment Policy

By signing below, I understand that full payment for all services and products I receive from is required at the time of service. I understand that I may submit my bill to my insurance carrier for reimbursement purposes and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

\_\_\_\_\_  
Signature of Patient

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## Consent Regarding Use of Information

\_\_\_\_\_ Some physicians use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to Sarita Elizabeth Cox to correspond with you via email in spite of these potential risks.

\_\_\_\_\_ Sarita Elizabeth Cox may engage in research into the efficacy of the therapies used by physicians practicing here. To gather sufficient data it is necessary to collect information about conditions treated, therapies used and outcomes observed from patient charts. In this process, no information that could be used to specifically identify individuals is ever used; only general demographic information is attached to the clinical data. By initialing this line, you are consenting to allow Elizabeth Cox to include this anonymous data from your chart to conduct research to be published in the appropriate medical literature.

\_\_\_\_\_ Some practitioners in this clinic may have an interest in writing about alternative medicine and health care for the general public, either as fiction or nonfiction. By initializing this line, you are consenting to allow your medical history and care in our clinic to be used as an example or case history in such writing, with the understanding that all identifying information would be altered.

## Cancellation Policy

The cancellation policy requests 24 hours notice. If there is a need to cancel or reschedule within the 24 hour period, an administrative fee is assessed. If the session is unattended, the cost of the entire session is applied.

