NourishingLife
HEALTH CENTER

I, _____, hereby authorize Hillary Thing MS L.Ac.., to perform the following specific procedures as necessary to facilitate my treatment via in-person or virtual consultation.

- Medical History & Evaluation, including evaluation of diagnostic lab reports and medical history past and present;
- Medicinal Use of Nutrition: therapeutic diet, nutritional supplements;
- Herbal Medicine: botanical substances may be prescribed as teas, granules, tinctures, capsules, tablets, creams, plasters, or suppositories;
- Acupuncture, moxibustion, cupping, and other energetic or physical therapies;
- Detoxification Protocols: teaching techniques of cellular rehydration, colon cleansing, sauna, and other cleansing practices;
- Holistic Medical Lifestyle Counseling: may include recommendations for light therapy, exercise, sleep, stress reduction and other health generating practices.

I recognize the Potential Risks and Benefits of these Procedures as described below:

Potential Risks: allergic or Jarisch-Herxheimer reactions to prescribed herbs and supplements; side effects of natural medications. Hematoma or bruising from acupuncture or cupping.

Potential Benefits: restoration of health and the body's maximum functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert their practitioner if they know or suspect that they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the practitioner or any of the clinic personnel regarding cure or improvement of my condition.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional.

I understand that Hillary Thing MS L.Ac., does not function as a primary care physician. I understand that she does not replace the services of my primary care physician.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law.

I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three years, but no more than ten years after the date of my last visit.

I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

_____ _____

Date Signature of Patient

_____

Signature of Patient Representative or Guardian