Declaration and Consent for Naturopathic Treatment

Name _____Date of birth _____/_____/_____ Social Security #_____/_____/_____

Address _____ City _____

State _____ Zip code _____ Phone _____

The undersigned understands that any advice provided by The Center for Integrative Wellness, LLC is not mutually exclusive from any treatment or advice that the undersigned may now be receiving or may in the future receive from a healthcare provider. No person has suggested or recommended that the undersigned refrain from seeking or following the advice of a healthcare provider.

The undersigned understands that the advice rendered by The Center for Integrative Wellness, LLC may differ from those usually offered by allopathic medical doctors or other healthcare providers. The undersigned is aware that the practice of naturopathic medicine is not an exact science and acknowledges that no guarantees have been made as to the results of treatment.

The undersigned also understands that the recommendations made by The Center for Integrative Wellness are of a naturopathic/integrative practice and can be used as complementary healthcare along with allopathic medicine. The Center for Integrative Wellness employees may suggest a referral to another practitioner if they find it appropriate for optimal care.

I have received copies of the following documents from The Center for Integrative Wellness, LLC, and have read and fully understand the contents of these documents.

- ☐ Welcome Letter with Policy statements
- ☐ Michigan Patient Rights and Responsibilities
- ☐ HIPPA Privacy Practices notice
- ☐ Declaration and Consent for Naturopathic Treatment

Signature (Guardian if under 18) _____ Date _____

Bill Policy

Billing will occur through The Center for Integrative Wellness, LLC accounting office. Daily services rendered will be invoiced and available for your immediate review. Partial payments are available for established patients. Products that are not available on site will be shipped or can be picked up when they become available. We require a credit/debit card on file in order to ship out your supplements or for Skype/Phone appointments.

- ☐ Visa
- ☐ MasterCard
- ☐ Discover
- ☐ American Express

Credit Card # _____-_____-_____-_____ Expiration Date _____/_____ CCV ____

Signature _____ Date _____

Billing Address and Zip Code _____

I prefer to pay for services with a check at the time of service and/or send payment by mail before supplements are shipped.

Signature _____ Date _____