

INFORMED CONSENT FOR TREATMENT by JoAnna Forwell ND

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

Refusing any specific procedure will not affect your receiving other care or future treatments.

I voluntarily request JoAnna Forwell, ND, as my physician, and such associates, medical assistants and other health care providers as he may deem necessary, to examine and treat me and my health conditions. I understand that the course of treatment may include the use of multiple modalities of conventional, alternative and naturopathic medicine including nutritional supplements, prescription medications, bio-identical hormones, injection therapies, Prolotherapy, Platelet Rich Plasma, intravenous nutrients, chelation, spinal manipulation, traction, and other therapies offered by JoAnna Forwell, ND. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition and discuss treatment options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that to receive prescription medications, such as thyroid and bio-identical hormones, I must comply with the required laboratory retesting schedule in order to receive refills.

I understand that payment is due in full at the time of service for all office visits and procedures not covered by your health insurance. Dr. Forwell is a participating provider in several insurance plans. It is your responsibility to confirm eligibility and benefits. In general, office visits for evaluation and routine medical care are often covered by insurance plans subject to the terms of coverage, co-pays, coinsurance and deductibles. Many innovative, alternative and preventative therapies offered by Dr. Forwell are deemed investigational by insurance plans and are not covered. I understand that any expenses incurred are my responsibility and not that of any other person or insurance group. Many lab tests can be billed to your insurance; however the patient retains ultimate responsibility for any labs not covered by insurance. We will indicate which lab tests require payment at time of service before ordering the lab test. I understand that no claims or guarantees have been made for future insurance reimbursement of particular medical services.

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is our policy to require a medical release form before releasing medical records to anyone other than the patient.

I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

Print Patient Name (or Guardian)

Patient Signature (or Guardian)

Date

FOR MEDICARE ELIGIBLE PATIENTS:

I understand that Medicare does not cover medical services provided by Naturopathic Physicians at this time. I understand that Medicare does not cover any medical services provided by JoAnna Forwell, ND and that no insurance forms can be submitted by JoAnna Forwell, ND or the patient to Medicare or to Medicare supplemental policies. I understand that this agreement is a private contract between JoAnna Forwell, ND and the patient for services provided to Medicare eligible patients and is excluded from Medicare reimbursement rules.

Print Patient Name (or Guardian)

Patient Signature (or Guardian)

Date