

INTEGRATIVE CARE CONSENT FORM

Midway Center for Integrative Medicine (MCIM) offers nutritional care support through nutritional information and nutritional products to support health. Nutrients that are utilized include vitamins, minerals, amino acids, and herbs. These nutrients are not specifically approved by the Food and Drug Administration for any medical condition. As with pharmaceutical treatments, there can be side effects to these approaches and interactions with medications that could be life threatening, cause morbidity, or lead to hospitalization.

By signing this form, I, the patient, acknowledge that these could occur and pledge to seek immediate care if there is concern (an example is bleeding). I, the undersigned, assume all responsibility for decisions I make regarding use of nutrients, recognizing that: A) no claims are made that dietary, nutritional, or herbal recommendations can treat or cure any medical condition, B) all recommendations are given for informational purposes only, C) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendation, and D) I am free to act upon or disregard the recommendations of James P. Roach, MD; Dee Dee Carman, APRN-C; Wendy Enneking, APRN-C; Angela Rutledge, APRN-C; and Lisa Carson, ND as I choose. I hereby release James P. Roach, MD;; Dee Cee Carman, APRN-C; Wendy Enneking, APRN-C; Angela Rutledge, APRN-C; and Lisa Carson, ND from all responsibility for my actions and any consequences thereof in the present time and in the future with no constrains. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of the MCIM team including any one of these practitioners to participate in a professional relationship with them pursuant to the statement herein.

Due to the potential for interaction with medicine, we recommend that you keep other healthcare providers informed of nutrients you take. We strive to make you aware of all options for your care including prescription treatments. If prescription medications are the approach you wish to take, please let us know and disregard nutrient recommendations.

Our office rarely uses scheduled prescription drugs; please seek another practitioner if you feel you require use of these medicines.

Dated this _____ day of _____, 201____.

Patient Signature

Printed Name

Witness Signature