

PATIENT: _____ **DATE:** _____

DISCLOSURE AND CONSENT FORM

TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States. ***NOTICE:*** Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.

I voluntarily request that **Dr. Don Colbert**, and other affiliated health care personnel as he may deem necessary, treat my condition (or the condition of the person for whom I am responsible) as described below:

I understand that some of, or all of, the following integrative and alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following: Administration of homeopathic remedies, herbal and nutritional therapies, off label use of pharmaceuticals, oxidative therapy, physical and/or quantum physical modalities (including osteopathy, light, color, electromagnetic and magnetic therapies) and extended neurological examination including neuromuscular and autonomic nervous system response as well as:

I understand that no warranty or guarantee has been made regarding results of treatment. I realize that there may be risks and hazards in treating this present health condition, with or without conventional medicine, and there may also be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox reactions) and undesirable interactions between various treatments, both conventional and alternative, as well as:

I have been given an opportunity to ask questions about the treatment of this health condition using conventional, integrative and alternative methods. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment, and I believe that I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), that the blank spaces have been filled in, and that I understand its contents. I also certify that Dr. Colbert has provided this Disclosure and Consent Form to me and fully explained the diagnostic and treatment options available and has made no guarantees to me as to the success of this treatment. I acknowledge that Dr. Colbert has informed me that he functions only as an educator and consultant not as the primary care physician for any patient. I have assured him that I have another primary physician and do not/ will not rely on Dr. Colbert for that role.

SIGNATURE OF THE PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON REQUIRED

BELOW:

SIGNED: _____

PRINT NAME ONLY IF OTHER THAN LEGALLY RESPONSIBLE PERSON:

_____ **DATE:** _____ **TIME:** _____ **AM/PM**

WITNESS SIGNATURE: _____