ALTERNATIVE HEALTH
Solutions

INFORMED CONSENT

It has been explained to me, and I understand that the physicians at Alternative Health Solutions, LLC are doctors of chiropractic and certified naturopathic physicians, not osteopathic or medical doctors. I understand that consequently, these physicians only provide care that falls under the Michigan Chiropractic Scope of Practice and national Scope of Practice for Naturopathic Physicians. They do not provide the type of care or treat conditions that fall within the scope of practice for medical doctors, nor do they treat or offer cures for cancer, diabetes or other acute or chronic disease(s) or illness(es).

I understand that nutritional advice that may be provided by physicians or staff at Alternative Health Solutions, LLC is not offered as treatment for a disease or illness. Such advice is offered only as a recommendation for support of the metabolic/structural systems of the body. Any direct treatment of disease(s) or illness(es) that I may have, must be administered by a medical or osteopathic doctor.

I have read this informed consent and understand it. I consent to examination and treatment and agree to hold harmless the physicians and staff at Alternative Health solutions for outcomes of treatment and/or recommendations which I may follow, as those outcomes relate to my overall health, or any disease(s), illness(es), or condition(s), which I now have, or may have in the future.

Additionally, I hereby state that I act solely on my own behalf during the course of the initial visit and any subsequent visit, and not as an agent for any federal, state or local agency (public or private), news media, or any law office and/or insurance company for the purpose of obtaining information to be used for investigation or entrapment.

___________________________________	___________________________________
Name of Patient	Patient Signature (or signature of personal representative)
___________________________________	___________________________________
Date	Personal representative’s relationship to Patient

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for all fees incurred at this office, regardless of my insurance status, and that payment for services is expected at the time services are rendered. I understand that any inquiry regarding special arrangements should be made prior to my initial visit.

___________________________________	___________________________________
Name of Patient	Patient Signature (or signature of personal representative)
___________________________________	___________________________________
Date	Personal representative’s relationship to Patient