TENPENNY

INTEGRATIVE MEDICAL CENTER

Tenpenny Integrative Medical Center
7380 Engle Road
Middleburg Heights, Ohio 44130

Consent for Homeoprophylaxis (HP)

I, _____, consent to participating in the HP program offered through Tenpenny Integrative Medical Center (TIMC), and/or consent to my child, _____, participating in the program.

I understand the HP program is intended to assist the body to develop resistance against several infectious/ contagious diseases. I understand the program is customized to meet the patient's age (infants to adults) and can be used to improve immune system for foreign travel.

I understand I will be administering the program at home and I will follow the instructions given at each session (in person or via phone) by one of our physicians. I agree to adhere to the program schedule and I agree to adhere to the follow up visits that are part of the program.

I understand the programs potential benefits and risks, and attest that all my questions have been fully answered. I have received printed instructions on how to administer the program. I understand that I can call the office for brief questions that arise during the course of the program at no additional fee.

I understand that the HP program is not a conventional vaccination or immunization program. I understand that the HP program may not be accepted by schools, by governmental agencies or by most medical practitioners as a substitute for conventional vaccination or immunization. I assume full responsibility for any adverse effects that may result from administration of the nosode program.

I understand that the program offers no guarantee that the person who participates in the program will not subsequently contract one of the diseases covered in the program.

I understand that the side effects or reactions to the HP nosodes, if they occur, are usually mild, transient, and self-limited. I acknowledge that reactions such as fever or a rash are the body's response to the immune-stimulating effects from the HP nosode (remedy).

I understand that by participating in this program, I give consent to the use of my treatment results as a testimonial.

I understand that I retain the right to suspend or terminate the treatment at any time, with or without informing my medical provider.

I fully understand that the HP program may be considered unproven by scientific testing and peer-reviewed medical publications, and therefore may be considered medically unnecessary or not indicated. Therefore, I waive any claim of damage by TIMC or my provider resulting from any adverse effect of the program.

I understand that my insurance company will not pay for homeopathic nosodes.

I further understand that other office visits and services, such as illness visits or check-ups, are not covered under the program fee, and I may be responsible for separate fees for those services.

I am aware of and understand the differences between homeopathic treatment and standard conventional medical care. I hereby acknowledge and consent to a holistic approach to my health concerns, and/or the health concerns of my child. I understand that by seeking a homeopathic approach, I will be receiving medical care according to the prevailing standard of the homeopathic medical community as expressed by the American Institute of Homeopathy. This type of care may not include blood tests, x-rays and other types of diagnostic tests that are typical for medical approaches.

I agree to hold those persons treating me, or my child, responsible only for the standards established by the Homeopathic medical community and I agree that I shall not hold my treating physician responsible to any other standard of care.

Parent/Adult Printed Name_____ DOB_____

Signature_____ Date _____

Child's Name_____ DOB_____

Child's Name_____ DOB_____

Child's Name_____ DOB_____