Mama Wu's Good Medicine
230 Hilton Lane
Londonderry, VT 05148
802-824-9950
mamawu@mamawusgoodmedicine.com

Informed Choice Agreement for Health Consultation

I, _____ am requesting an health consultation with Helena Wu. I understand that:
The work we do in consultations does not substitute for the care of a medical practitioner. Helena does not diagnose or claim to cure any physical or psychological conditions. Herbs, flower essences and energy work support the body to heal itself.

-I take responsibility for educating myself about my condition and any recommendations by asking questions, reading, research, etc.
-I take responsibility for any such recommendations I choose to follow and for all outcomes.
-I take responsibility for informing any healthcare practitioners I am working with about the herbal or flower essence therapeutics I am using.
-I will be honest about information I give about myself. I will communicate my feelings, concerns and questions to Helena so that there will not be misunderstandings.

-Helena will communicate honestly with me, explain clearly the assessments and recommendations, answer my questions and refer me to other healthcare practitioners as needed.
-Both myself and Helena have the right to discontinue the health consultant/client relationship at any point.
-I have been provided with a description of Helena's herbal, flower essence or Reiki practice qualifications and fees.
-I agree to pay for my consultations and remedies or abide by any alternate arrangements made.

Health Records Privacy Notice

Please initial the uses you approve of. Fill in names where appropriate.
___My health information shall remain confidential and not be disclosed to anyone unless at my request.
___My case may be discussed with others for educational purposes or research as long as all identifying information is removed.
___My information may be shared for collaborative care with other health care practitioners. List names:

___My information may be shared if requested by legal authorities
___My information may be shared to facilitate payment for services and remedies
___I give permission for the following family and friends to see my health information:

Signed: Date:
Print Name, Address, Phone: