Homeopathic Family Practice
Hannah Shalom DCHM (Hon) FCHM HOM
Homeopath

Pure, Simple and Amazing Inc.

DECLARATION AND CONSENT FORM
FOR HOMEOPATHIC ASSESSMENT AND TREATMENT

Patient Name _____ File No. _____

Practitioner: Hannah Shalom DCHM (Hon) FCHM Homeopath Registration #: 15459

ASSESSMENT and RECOMMENDED TREATMENT (including those by referral to another practitioner)

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Homeopathic remedies are natural substances that have been diluted and are used to help your body to make use of its own healing energy to solve its dis-ease challenges.

I acknowledge and declare that I have the option of seeking and/or continuing conventional medical care from a qualified medical doctor and I am aware that homeopathic treatment and conventional treatment are not mutually exclusive.

I understand that in the event of medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to reach my homeopath.

I understand that Homeopathic medicine is interactive, and I am fully involved in the healing process.

I understand that my appointment time has been reserved especially for me. Cancellations made without 48 hours' notice or missed appointments, will be charged the full visit fee. I agree to pay all fees on the day of my visit. We accept cash, cheque, Visa or MasterCard.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the assessment and recommended treatment described above and have discussed to my satisfaction this and any requests for related information with the Homeopath named above. I have been given the opportunity to ask questions about the assessment and recommended treatment and have received answers to such questions. I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, material risks, material side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

As a result, I do hereby voluntarily provide my informed consent for the recommended treatment specified above.

Date: _____

Signature: _____