

### ***JLopezMD Medical Group General Consent Form***

As a patient I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as whether or not to undergo care having had the opportunity to discuss potential benefits, risks, and hazards involved.

I hereby request and voluntarily consent to examination and treatment with integrative medical care, possibly including homeopathic medicines, vitamins, minerals, supplements, IV therapies, ozone therapies, injections, detoxification treatment modalities, lab testing, nutrition recommendations, etc. for me (or for the patient named below, for whom I am legally responsible) by JLopezMD Medical Group, or those working or training at the office who now or in the future may treat me while employed by, working or training with, or serving for back up for the aforementioned. I can request that students not be included in my evaluation and treatment. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

I understand that the Philippine Food and Drug Administration has not fully evaluated or approved nutritional, herbal and homeopathic supplements, compounded IV's/injections, ozone therapies, bio-identical hormone replacement therapies; however, they have been widely used in Europe and the U.S for years. I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to certain pre-existing disease conditions. I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment, that the medical provider feels at the time, based on the facts then known, is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

It is my responsibility to keep my medical provider up to date with all of the current medications and supplements that I am taking, so that he/she can make the best informed recommendations for my care.

I have the opportunity to ask questions and discuss with my provider to my satisfaction:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherited risks, complications, potential hazards, or side effects of the treatment or procedure
- the probability or likelihood, of success
- reasonable available alternatives to the proposed treatment or procedure
- the possible consequences if treatment or advise is not followed and/or nothing is done

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I understand that integrative medicine, evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, ordering diagnostic imaging, prescription of certain medications and nutritional supplements, IV therapy, HBOT (Hyperbaric Oxygen Therapy), medical ozone treatment/therapy, bio-identical hormone replacement therapy, injections, counseling, dietary therapies, infrared sauna, colonics, and homeopathic or other alternative remedies.

I understand that the medical providers at JLopezMD Medical Group have been trained in a diverse range of diagnostic and treatment options. I understand that JLopezMD Medical Group is highly specialized and based upon evidence-based medicine, including biological medicine, functional medicine and holistic principles. As such, they may recommend different tests; may interpret standard tests differently; may propose different treatments, or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non-traditional, non- conventional or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence-based functional and integrative medicine.

By signing this form, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by JLopezMD Medical Group and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my physician for a more detailed explanation.

**Name\*** \_\_\_\_\_ **Date Signed\*** \_\_\_\_/\_\_\_\_/\_\_\_\_/

**Email\*** \_\_\_\_\_

**Signature\*** \_\_\_\_\_  
Signature of patient or guardian