PHUSIS-5331
Jurgen Bode
X2367976B
Naturopath (Col. 4914)

INFORMED CONSENT

Naturopathy, massages and wellness services provided by a professional naturopath

CLIENT:	ID / PASSPORT:	DATE OF BIRTH:
ADDRESS:		PHONE:

If the client is a minor:

LEGAL GUARDIAN:	ID / PASSPORT:	RELATIONSHIP:

I REQUEST AND AUTHORIZE: The company named above, assisted by the professional mentioned above, to carry out the procedures and treatments that are considered necessary within their professional scope, as well as the training and advice for my person.

GENERAL INFORMATION:

1. Professional intervention in naturopathy, massages and wellness aims to achieve a hygienic-dynamic action (Health-Dynamism) – a health-dynamizing action – to help recover, maintain and improve health and beauty in a natural and healthy way, thereby increasing quality of life and achieving a state of harmony and general well-being for a better quality of life.
2. The professional relationship between the client/consultant and the practitioner is established as a provision of services. It is based on a relationship of trust and confidentiality, as the practitioner acts as a personal advisor and is bound by the professional code of ethics, secrecy and professional ethics, the data protection law and the duty to safeguard confidentiality and the privacy of the client/consultant.
3. The treatment will consist of:
   - Ayurveda – Definition and delivery of Dosha profile + Sub-Type
   - Bach Flower Therapy – Preparation of personalized formula + Instructions
   - Acupressure – Preparation of Body Map and Instructions
   - Aromatherapy – Preparation of personalized therapy and Instructions
   - Bach Flower Therapy – "Bach Flowers" – Delivery of Body Map and Instructions
   - Diet therapy and Tropology – Preparation of Holistic Diet – Personalized according to Dosha / Yin Yang Concept / Joys / Genetics / Other
   - Phytotherapeutic Medicine – Preparation of herbal recipes and/or phytonutrient formulas with Instructions
   - Hematological Analysis, Interpretation and Hematological Evaluations – Based on Ideal Values (Personal) to Identify, Diagnose, Monitor and Treat Diseases, Imbalances and Dysfunction.

   For more information on this matter, an annexed document is attached as the corresponding information.
4. There is no absolute guarantee of results and procedures performed; however, consistency is required to achieve greater effectiveness.
5. Contraindications or side effects: The proper application of the treatment and/or the training/advice, together with the indications and recommendations made by the practitioner, has no side effects, is harmless and in no way is or should be a substitute for medicine or the corresponding medical prescription.
   Despite the appropriate choice of method or technique and its correct application, risks in general are infrequent, rare or relatively mild and practically non-existent; however, some undesirable effects specific to the procedure may occur, such as general discomfort typical of the treatment, which will subside fairly easily and in a short time, afterwards improving and giving rise to a feeling of well-being.
6. If after carefully reading this document you would like more information, please do not hesitate to ask the person in charge, who will be glad to address any questions, clarifications and/or options applicable to your particular case.

CONFIRMATION: In light of the above, I CONFIRM that everything has been explained to me in detail, allowing me to understand the effect and nature of the procedure to be performed. Likewise, I have not omitted any information about my current state of health that would contraindicate the treatment and procedure. If at any time my current state changes, I will inform the practitioner so that they may assess whether any changes are required to the initial treatment.

DECLARATION: Having had the opportunity to clarify all my doubts with answers to my questions in the personal interview, as well as understood the meaning of the procedure and the inherent risks, and having made the decision freely and voluntarily, I formally declare that I have been duly informed of all of the above. Likewise, I assume as my own risks not following the recommended indications and the contraindications advised, as well as problems derived from inadequate post-treatment care, as a consequence of the particularities of my case, releasing the Center/Company from any inconveniences that may arise.

CONSENT: Therefore, having had all the questions I have freely asked answered satisfactorily, I give my consent regarding the entire procedure, and therefore I sign this informed consent, for all applicable purposes.

In the city of _____ (_____), on the _____ day of _____ 20_____.

Client: _____ ID / PASSPORT: _____ Signature: _____

Legal representative: _____ ID / PASSPORT: _____ Signature: _____

Refusal or Revocation

I, Mr./Ms. _____, after being informed of the nature and risks of the proposed procedure, freely and consciously express my refusal / revocation (delete as NOT applicable) for its performance, assuming responsibility for any consequences that may result from this decision.

In the city of _____ (_____), on the _____ day of _____ 20_____.

Client: _____ ID / PASSPORT: _____ Signature: _____

Legal representative: _____ ID / PASSPORT: _____ Signature: _____

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