**Mariana Sullivan Homeopathy**

918-688-0316

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**ADULT CONSENT FORM**

* I acknowledge that I am over 18 years of age.
* I acknowledge that the decision to seek homeopathic treatment is my own decision and I have voluntarily chosen homeopathy to support my health needs.
* I give consent to be treated by this homeopath according to the homeopathy principles and methods explained to me previously.
* I understand what has been explained to me about the nature and safety of homeopathic medicines (remedies) and possibility of short-term physical or mental aggravations.
* I am aware that the outcome and duration of the treatment may vary by individual and can not be guaranteed.
* I acknowledge that to the fullest extent permitted by law, the healthcare provider administering this homeopathic treatment shall not be held liable for any unwanted effects, complications, or outcomes resulting from this treatment. I absolve the healthcare provider from any responsibility or liability related to my participation in this treatment.
* I willingly consent to participate in this homeopathic treatment and will actively engage in the process, providing accurate and complete information about my health and well-being.
* I understand that the homeopath I will be seeing is not a medical doctor and does not diagnose.
* I understand that any suggestion given will not be taken as a medical diagnosis or direction against a licensed medical or mental health care professional.
* I understand that it is my responsibility to maintain a relationship with a licensed physician or a PCP for appropriate evaluations and check-ups.
* I acknowledge that I have not been advised at any time to stop seeking allopathic treatment (medical doctor or MD), and that standard medical treatment must be obtained from a medical doctor.
* I give permission to this homeopath to contact my physician or PCP if necessary. I also give permission to my homeopath to discuss information in my files if contacted by my physician or PCP.
* I accept full responsibility for fees incurred during care and treatment, and agree that payment is due when services are rendered (by the end of each visit), unless prior arrangements have been made.
* I understand that I have a choice from where to obtain the homeopathic remedies recommended and I agree to take the remedies as instructed by this homeopath.
* I understand that it is my responsibility to inform this homeopath of any changes made to my mailing address, email address, home phone/ mobile phone, etc. to help ensure proper delivery and confidentiality of information.
* I grant permission for this homeopath to upload and store confidential information - including account, appointments, and clinical notes, to their files/ database.
* I understand that all information disclosed is confidential and protected by HIPPA laws.

I verify that I have read, understand and acknowledge the terms of service outlined in this consent form.

**Client Full Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_