Consent to Diagnose and Treat

Kathleen Lanka MS, FNP

I hereby request and voluntarily consent to evaluation and treatment with holistic medical care, possibly including traditional and compounded medication, vitamin and herbal supplements, blood or saliva testing, nutritional, and lifestyle recommendations for me by Kathleen Lanka MS, FNP. I can request further explanation of the treatment and risks of any treatments.

I understand that the US Food and Drug Administration has not fully evaluated or approved nutritional and herbal supplements, and bioidentical hormone replacement therapies; however, they have been widely used in Europe and the US for years. I understand that, as with drugs, hormones and nutritional supplements may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medication 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 treatment that she feels is safe at the time, based on the facts then known, that is in my best interest. I understand that if I do not take the treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

It is my responsibility to keep the medical provider up-to-date with all current medication and supplements that I am taking so that 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 inherent risk, complications, side effects of the treatment, the probability or likelihood of success, reasonable available alternatives to the proposed treatment or procedure, the possible consequences of the treatment or advice if not followed and/or if nothing else is done.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I recognize that proposed treatments and services may be considered non-traditional, non-conventional, or alternative medicine. I recognize that this treatment, like any treatment, may have risks and/or side effects.

By signing this form, I acknowledge that I have carefully read and understood the above consent. I give my permission and consent to care and authorize medical treatment by Kathleen Lanka 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 provider for a more detailed explanation.

_____

PRINT PATIENT NAME

_____ _____

SIGNATURE OF PATIENT (OR GUARDIAN) DATE