

Nature's Restorative Health

Informed Consent Form

I fully understand that Alicia Agard natural health advisor who deals strictly in helping people to improve their general health, stress reduction and imbalances for health enhancement.

I fully understand that Alicia Agard is not a licensed physician (MD) and cannot diagnose disease, prescribe drugs, or recommend treatments for specific disease conditions.

I understand that all evaluations/analysis performed by **Alicia Agard/Natures Restorative Health** designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through natural remedies and lifestyle modification. I further understand that said evaluations and services cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by medical physicians.

It is very important that you are completely forthright in informing your Practitioner of any disease process currently going on in your body, if you are on any prescription medications, over the counter, or illegal drugs.

I understand that Alicia Agard will never claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services, or products she provides, whether in person or remotely will cure, treat, prevent, or mitigate any disease condition.

I certify that I am here on this and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

I hereby request and consent to Wellness Consultations and the performance of: Bioenergetic screening, Bio magnetic, Tuning Fork, Singing Bowls, Acupressure, Korean Hand Therapy, Auricular Therapy services and other procedures within the practice of auriculotherapy on me (or on the patient/client named below, for whom I am legally responsible) by Alicia **Agard/Natures Restorative Health**. I understand that methods of service may include, but are not limited to ear seeds, auricular massage, Tuning Forks, laser, electric stimulation, palpating, and other forms of stimulation.

If I have a known allergy or sensitivity to gold, nickel, latex or any metals and adhesives. I will immediately **notify Alicia Agard/Natures Restorative Health** of any unanticipated or unpleasant effects associated with adhesives or metals.

I have been informed that services such as:

Homeopathic remedies and Therapeutic detoxification

There may be some slight discomfort from various Holistic therapies. These include but are not limited to:

- Going through the healing crisis
- Effects to detoxification which may include headaches, nausea, flu like symptoms,

Korean Hand Therapy is a generally safe method of treatment, but that it may have some side effects including dizziness, feeling faint, bruising, itchiness, burning, tingling or pain on the hand.

Bio-magnetic Therapy is a generally safe method of treatment, but that it may have some side effects including dizziness, feeling faint, bruising, itchiness, burning, tingling.

Auriculotherapy Therapy is a generally safe method of treatment, but that it may have some side effects including dizziness, feeling faint, bruising, itchiness, burning, numbness, tingling or pain on the ear or hand that may last a few days.

Unusual risks of ear seeds include: the ear seed dislodging or falling into the ear in which a saline wash performed by my doctor would be recommended to remove it. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the - **Alicia Agard/Natures Restorative Health** to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on - **Alicia Agard/Natures Restorative Health** to exercise judgment during the course of treatment which she thinks at the time, based upon the facts then known is in my best interest.

I will notify - **Alicia Agard/Natures Restorative Health** if I experience any side effects.

I will notify – **Alicia Agard/Natures Restorative Health** if I am or become pregnant, or breast feeding

I will notify – **Alicia Agard/Natures Restorative Health** if I have a pacemaker, implants (metal or other types of implants), had an organ transplant.

I understand that results are not guaranteed.

I understand my client records and lab reports will be kept confidential and will not be released without my written consent.

Medical Referral I understand that none of the above services are meant to replace conventional medical treatment and that- **Alicia Agard/Natures Restorative Health** recommends I see my physician for all health matters.

I or my representative release and hold harmless Alicia Agard/Nature's Restorative Health from and against any and or claim or liability whatsoever kind or nature arising out of my sessions.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of the above services and procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Participant:

Signature of Participant: _____ Date: _____

MINOR INFORMATION:

Name of Parent/Legal Guardian: _____

Age (If A Minor) _____

Signature of Parent/Legal guardian: _____ Date: _____

Copy to be given to client. Maybe reviewed with client periodically.

Date copy given to client. _____ in person, via email, Mail. ___