Consent to Treatment – Homeopathic Medicine

Homeopathy and other holistic methodologies view health and illness from a different perspective than the standard, conventional medical approach (which limits its concerns to individual symptoms). The homeopathic interview takes the whole person into consideration, and regards the spiritual, mental, and emotional symptoms to be as important as the physical aspects.

Homeopaths do not make any sort of diagnosis in medical terms and it is your responsibility to maintain a relationship with a licensed physician or primary care provider for appropriate evaluations and check-ups. It is recommended that you inform your primary care provider that you are receiving homeopathic treatment. Under no circumstances should any suggestions be taken as a medical diagnosis or direction against a licensed medical or mental health care professional.

Please initial the statements below:

_____ I understand that rather than medical advice or treatment, I am seeking holistic treatment in the form of lifestyle, educational, nutritional, and homeopathic advice and /or recommendations. I understand that the goal of homeopathy is to increase my (my child's) general vitality and constitutional strength and that no specific disease will be diagnosed or treated.

_____ I understand that minor aggravation or worsening of some symptoms may occur temporarily as part of the healing process.

_____ I authorize discussion of my case notes with other professional homeopaths if my (my child's) best interests be served by such a consultation. My right to privacy will be protected by withholding my name and any other identifying information.

_____ I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself / my child.

_____ I am aware that the outcome and duration of homeopathic treatment vary by individual and cannot be guaranteed.

Patient Information

Patient Name: _____ Date of Birth: _____

Parent Name (if minor): _____ Best Contact Number: _____

Best Contact Number: _____

Address: _____

Primary Care Provider Name: _____ Phone: _____

Signature of Patient or Guardian: _____ Date: _____