Symphony Healthcare, Inc
www.shcocala.com Phone: 352-629-5939

Functional Medicine Treatment Protocol Informed Consent

You are about to begin an Integrative medicine treatment approach to your healthcare. As you may already realize, many of the recommendations you receive during this treatment are different from those which other traditional physicians may have previously made. As a functional medicine practitioner, I will make recommendations to address imbalances in all areas that I have observed need treatment. Functional medicine addresses the underlying root causes of disease, using an approach that engages both the patient and the practitioner in a therapeutic partnership. Rather than traditional medications or prescriptions, a stimulation of natural healing will be emphasized. In my experience, I feel that these are the most effective ways of dealing with most of the chronic health problems in our culture.

Natural treatments do not typically work quickly, but they work over time in a cumulative fashion. It is important that you follow the plan exactly as prescribed to receive the maximum benefits. All elements of treatment are important and work synergistically together. If at any time you feel that you will have difficulty or are unable to comply with treatment, please let our office know and we will make the appropriate referrals to a practitioner that might be a better fit for you.

As part of my treatment philosophy, there are times when diagnostic testing might be necessary, and I will recommend the appropriate testing when needed. You have the right to refuse diagnostic testing at any time; however, I will be unable to properly manage your healthcare without the testing. Alternatively, when utilizing a functional medicine approach, there are times when diagnostic testing is not indicated as it would be with traditional medicine. You have the right to utilize a practitioner that might be a better fit for you or a specialist for certain conditions.

- ____ I agree to follow the plan of care created for me at my visits.
- _____I agree to be an active participant in this plan to achieve optimal outcomes.
- ____ I agree to follow-up office visits as requested by my provider.
- ____ I agree to lab testing as requested by my provider.
- ____ I agree to keep a credit card on file to use for payment of my office visits, late cancellations and no-show fees.
- ____ I will notify Symphony Healthcare if I want to opt out of this agreement. Doing so may change which medications and testing will be offered.

I certify that I have read or had read to me the contents of this form. I understand both the benefits and risks of proceeding with the functional medicine approach. I also understand the risks and consequences associated with my refusal to any specific recommendations given to me. I understand that functional medicine is not traditional medicine and should I require any traditional medical intervention, my care may need to be referred to the appropriate practitioner. My signature below reaffirms that I will hold Symphony Healthcare, Inc. and its employees harmless.

Patient Name/Date: _____