Natural Medicine Centre

HCR Therapy
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CONSENT TO TREATMENT

Patient Name _____ Date of Birth (D/M/Y) _____

Patient's address: _____

City:_____Postal code:_____Tel. #: _____

Email Address (if available):_____

PATIENT'S CONDITION: _____

_____

_____

PLEASE READ CAREFULLY AND COMPLETELY:

1. I acknowledge that I am suffering from the condition described above. I freely and voluntarily consent to the treatment or procedure described in paragraph 2 (below) by Helga Freitag and other persons of her choosing.

2. I understand that this treatment consists of some or all of the following: Electro-acupuncture Testing, Application of Homeopathic Combinations, and Electrical Massaging (applicable to Patients treated at the Natural Medicine Centre).

3. (a) I am aware of and have had explained to me that there are certain risks and reactions associated with the treatment. The primary risk is detoxification and symptoms associated with detoxification. To lessen these symptoms it is advisable that I drink two litres of water per day during the course of the treatment.

(b) I also understand that the side effects associated with homeopathic treatment are minimal, and, that other than detoxification and associated symptoms mentioned above, the treatment should not worsen any health condition I have.

(c) These risks have been explained to me by Helga Freitag & associates, and I freely assume them.

4. (a) I understand that the likely benefits of the treatment are as set out in the patient information pamphlet that I have received and read (see flyer in waiting room or available on the website "HCR Therapy").
(b) I understand that optimal results are only possible if the series of treatments is completed. The number of treatments required may vary according to the individual patient. The treatment is not completed after only one visit/session.

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(c) I have received and understood the explanations of the treatment, any alternate courses of action and the associated risks and any side effects. I have also received understandable answers to any requests I have made for additional information regarding the treatment.

(d) I acknowledge that no assurance or guarantee can or has been given that this treatment or any other treatment will improve my condition. I acknowledge that Helga Freitag is licensed under the Regulated Health Professions Act and I understand that the treatment has not been scientifically proven to be effective.

5. (a) Prior to the commencement of treatment I agree to advise Helga Freitag which medications I am currently taking, whether I have a pacemaker, whether I am pregnant, and any other medical conditions I have. I agree to advise Helga Freitag of any changes in the medications I am taking and any changes in my health during the course of the treatment.
(b) I understand that I have to continue taking the medication(s) prescribed by my doctor(s) during the course of the treatment. Should my prescribed medication(s) need to be adjusted, I must consult my doctor before doing so.

6. (a) I understand that this treatment is not covered by OHIP and that the cost per adult is:

(i) $100 + tax for the first test; and
(ii) $70.00 + tax for each additional follow-up test.

(b) The cost per minor under the age of 18 is:

(i) $70.00 + tax for the first test; and
(ii) $50.00 + tax for each additional follow-up test.

The cost of the medication is an additional $23.00 + tax per medication for adults. Total for both medication and initial test is approximately $300.00, depending on how much medication you require.

(c) Payments must be rendered prior to shipping the remedies with no exceptions. Payments may be made by Visa, Mastercard, American Express or Personal Cheques. Patients will be charged $50.00 CAD for every cheque which is returned for insufficient funds and any outstanding accounts will be forwarded to a collection agency (bank charge for cheques with insufficient funds is $25.00 per party). Failure to pay an outstanding account will result in all further treatments or procedures being cancelled.

Date: _____ Patient's Signature*: _____

* OR SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS UNDER THE AGE OF 18 yrs.