11 Woodland Road. Madison, Connecticut

06443
Adonai Optimal Health and Wellness, LLC
Fax (203) 318-5203

Phone (203) 318-5200

INFORMED CONSENT FOR TREATMENT

I hereby authorize Dr. Yvette M. Whitton, physician at Adonai Optimal Health and Wellness, to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

- ***Common diagnostic procedure**: e.g., venipuncture, pap smears, radiography, laboratory and x-ray, as applicable.*
- ***Minor office procedures**: e.g., dressing a wound, eye/ear irrigation.*
- ***Medicinal use of nutrition**: therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.*
- ***Botanical Medicine**: botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.*
- ***Homeopathic Medicine**: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.*
- ***Lifestyle counseling and hygiene**: diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.*
- ***Psychological counseling, Physical medicine, Acupuncture and bodywork**.*

Dr. Yvette M. Whitton of Adonai Optimal Health and Wellness, has discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

***Potential Risks**: allergic reactions to prescribed herbs and supplements; side effects of natural medications; inconvenience of lifestyle changes; bleeding, bruising or pain with venipuncture; possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding or redness. Physical Medicine may result in temporary pain or discomfort.*

***Potential Benefits**: restoration of health and the body's maximal function capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.*

NOTICE TO PREGNANT WOMEN: *All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures therapies described above may present a risk to pregnancy.*

Alternatives- I understand that Dr. Yvette M. Whitton of Adonai Optimal Health and Wellness is a Naturopathic physician, not a primary care physician, and the procedures that I will receive serve as supplementary care to my primary care physician and/or specialist. *It has been recommended to me that I consult with a primary care physician and/or specialist to obtain information about all of the conventional medicine treatment alternatives available to me.*

CONSENT*: With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees have been given to me by Dr. Yvette M. Whitton regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.*

CONFIDENTIALITY*: I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by my lawful representative, or me or unless law permits or requires it. I understand that my request to view or receive a copy of my medical record can only be done with a signed form of records release from Dr. Whitton. I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.*
I certify that I have read and fully understand this consent and matters that have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely voluntarily.

_____ _____
Patient Name (Please Print) *Signature of Patient*

_____ _____
Date *Signature of Patient Guardian*

Notes _____

_____

_____