Dr. James Skeen
Integrative and Regenerative Medicine

Consent for Treatment

I, _____ (print full name here) hereby authorize Dr. James Skeen to perform procedure necessary to facilitate diagnosis and treatment and may include, but is not limited to: General Diagnostic Procedure of a disease or disorder and may include but is not limited to, venipuncture, gynecological exams, pap smears, blood and urine lab-work, stool testing, general physical exams, and neurological and musculoskeletal assessments including ANSAR, and LEAP. I am aware that my health insurance may not cover some of these diagnostic costs and I am responsible for any unpaid balance.

Treatments may involve, but are not limited to: lifestyle counseling, exercise, prescription medications, herbs and natural medicines, natural substances (pills, powders, topical creams, suppositories, supplements) dietary advice and therapeutic nutrition involving but not limited to the use of foods, diet plans or nutritional supplements for treatment, intramuscular vitamin or other injections, oral and IV chelation and other IV therapies. and bioidentical hormone replacement including hormone pellets.

Potential risks of the above therapies include pain, discomfort blistering, discoloration, infection, burn, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapie; allergic reactions to prescribed herbs or supplements, aggravation of pre-existing symptoms. Allergic reactions and gastrointestinal upset may include rash, hives, nausea, vomiting, itching, gas, headache, tongue swelling, and impaired breathing.

Many treatment protocols are outside of the standard of care used by traditional doctors. Some labs used to diagnose are not traditional, and the diagnosis could be outside of that a traditional physician might give. Dr. Skeen will be happy to explain the science and studies that back your treatment plan, and can give you reference material if needed.

Prescribed herbs, homeopathic medicines and nutritional supplements, derived from plant, animal, mineral and other sources, are considered safe when taken as indicated by the prescribing medical practitioner. It is critical that patients follow the prescribed recommendations when taking herbs, bioidentical hormones and nutritional supplements because they may be toxic if misused.

I understand that herbs may have an unpleasant smell or taste. I understand that some herbs, hormones, and supplements may be inappropriate to use during pregnancy. I will notify Dr. Skeen immediately if am currently pregnant or become pregnant during the course of treatment. I understand that herbal, hormonal, homeopathic, and vitamin therapies, like pharmaceutical prescriptions are not inert substances and may have serious side effects. I will immediately inform Dr. Skeen if I experience any gastrointestinal upset, allergic reactions or any unanticipated or unpleasant effects associated with the bioidentical hormones or other supplements prescribed. I understand that it is my responsibility to immediately inform Dr. Skeen of any new symptoms that arise during treatment that could be considered an adverse reaction. I understand other side effects and risks may occur. To properly treat the medical conditions Dr. Skeen must be contacted immediately if an adverse or conditions occurs. If an emergency medical condition arises and I cannot reach Dr. Skeen, I will seek immediate treatment from a trauma center or call 911. I understand that I am responsible for all costs associated with medical treatment obtained from Dr. Skeen or other physicians, hospital or medical facilities. I am aware that all existing methods of diagnosis and treatment including integrative and regenerative healthcare pose some level of risk. Within a general healthcare setting possible adverse outcomes of these practices range from minor to fatal. I understand that I may ask questions regarding my treatment before signing this form and I am free to discontinue participation in treatment at any time.

With this knowledge, I voluntarily consent to treatment using some or all of the above procedures. I realize that no guarantee of treatment has been given to me by Dr. Skeen. I understand that a record of health services provided to me and will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon and that obtaining a copy of my record may require a fee.

_____ _____

Signature Authorized representative of a minor

_____ _____

Witness Date

Visits

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