Radiant Heart Center for Wholeness
Ali Givens, ND / Michael Givens, L.Ac.
12160 SE Mt. Scott Blvd.
Happy Valley, OR. 97086
503.609.0890

Declaration and Consent to Treatment

Even the gentlest therapies have their complications. Certain conditions such as pregnancy, lactation, or those on multiple medications, or, who have certain diseases such as diabetes, heart, liver or kidney disease, or, who are very young need to proceed with caution in treatment. It is very important that you inform your Naturopath or Acupuncturist immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

There are some potential health risks to some treatments. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from Venipuncture or Acupuncture
- Muscle strains, sprains or disc injures from spinal manipulation
- The potential for stroke in neck manipulation (Tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare, occurring approximately 1 in 1.5 million manipulations).

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 so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that Dr. Ali Givens and/or Michael Givens will answer any questions that I have to the best of their abilities. I understand that results are not guaranteed. I do not expect them to be able to anticipate and explain all risks and complications. I will rely on them to exercise their judgment during the course of procedures which they feel are in my best interest, based on what is known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

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I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment, I must provide at least 24-hour notice in which case, no charge will be applied to my account.

Payment is due in full at the time of treatment. Checks, cash and credit cards are accepted. We charge a 3% processing fee for credit cards.

I have read and agree to the above statements.
Initials __________

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THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient, is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive from another licensed health care provider;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in the United States;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different from those offered by a medical doctor or other licensed health care provider.

V. Radiant Heart Center does not directly bill insurance. I may request a super bill to provide any insurance carrier that I have to be reimbursed for my payment to Radiant Heart Center for Wholeness.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

Patient's Full Name: ____
First Middle Last

Date of Consent: ______________________________
Day Month Year

Provider: ___________________________
Ali Givens, ND / Michael Givens, L.Ac.

X ____

Signature of Patient (or Parent or Legal guardian)

Phone Number: ___________________________________