Dear Patient:

Welcome and thank you for choosing Medicine 369 for your medical care. As you are aware, this center is an alternative/complementary/integrative/holistic medical practice. The treatment rendered at this facility may be considered experimental and/or may not be considered usual and customary.

By signing below, you are hereby acknowledging that after having carefully considered all of the medical options made available to you, including the risks and benefits involved, you subsequently decided to pursue an alternative/experimental/complementary/integrative/holistic approach to your treatment at this center in light of the inherent risks and possible consequences, as well as potential benefits.

In addition, Medicine 369 (Fred Pescatore MD, MPH, Richard Smith DO) does not hold hospital admitting privileges at any local hospitals, and you are advised to have another attending physician that can provide such services to you in the event such services should be necessary. This is strictly an outpatient medical practice; although the center is always available to you should you require our opinion.

Furthermore, under the circumstances, you hereby waive any rights to reimbursement, although in some cases reimbursement may be forthcoming.

The specific treatment(s) for which you are waiving your reimbursement rights and acknowledging informed consent is/are as follows:

1. __________________________ Date _______ Pt. initials ____ MD initials____
2. __________________________ Date _______ Pt. initials ____ MD initials____
3. __________________________ Date _______ Pt. initials ____ MD initials____

Physician Signature: ____________________________ Print: ____________________________

Patient Signature: ____________________________ Print: ____________________________