GracePointe Healthcare PLLC
Modern medicine the old fashioned way

1311 West Main Street
Franklin, TN 37064
(615) 599-6868 Fax: (615) 599-6988

Functional Medicine
Informed Consent: Diagnosis and Treatment

The intention of this consent form is to help patients, clients, and authorized representatives become better informed so that they may give or withhold consent to undergo diagnosis and treatment after having an opportunity to discuss health concerns, including potential benefits and risks, and treatment alternatives.

I, _____PATIENT, CLIENT, or AUTHORIZED GUARDIAN or REPRESENTATIVE (hereafter referred to as "patient or representative"), acknowledge the opportunity to read and inquire about this consent and all the items addressed herein and hereby authorize (hereafter referred to as "clinician"), in accordance and within the scope and limits of their clinical license(s), to perform or recommend any of the following procedures for diagnosis and/or treatment:

- **Common Diagnostic Procedures:** venipuncture, radiography, laboratory, x-ray, ultrasound, etc.
- **Alternative Diagnostic Procedures:** including diagnostic methods, functional laboratory testing, and devices that may fall outside of the "conventional standard of care."
- **Medical Nutrition:** therapeutic nutrition, nutritional supplementation, and intramuscular vitamin, mineral, amino acid, lipid, phytonutrient, and metabolite precursor and other nutrient injections, as permitted by licensure.
- **Botanical Medicine:** medicinal herbs and plant derivatives prescribed as loose teas, alcohol or glycerin tinctures, capsules, tablets, creams, suppositories, etc.
- **Intravenous Therapies:** including high-dose vitamin, mineral, amino acid, lipid, botanical, and other nutrients.
- **Minor Office Procedures:** wound dressing, ear cleansing, sutures, biopsies, immunizations, etc.
- **Physical Medicine:** massage, stretching, exercises, contrast heat/cold applications, and manual or instrument-assisted joint mobilizations, as permitted by licensure.
- **Lifestyle and Wellness Counseling:** to promote improved wellness through lifestyle strategies, including recommendations for dietary changes, sleep, exercise, stress management, work-life balance, self-care, and developing and nurturing healthy relationships. This excludes specific treatment for known or suspected mental illness.
- **Prescription Medications:** as allowed by the clinician's licensure and for both FDA-approved and non-FDA approved (i.e., "off label") applications.
- **Hormonal Replacement:** oral, transdermal, injected, or device-implanted hormonal applications intended to restore symptomatic patients to levels at or above age-appropriate hormone levels through bioidentical, synthetic, and animal-derived preparations.
- **Group Counseling:** to facilitate efficient and effective community creation and education regarding the diagnosis, treatment, and management of health concerns.

Informed Consent:
_____ **(Patient's or Representative's Initials)** acknowledges the right, opportunity, and responsibility to ask questions and to become informed regarding the clinician's diagnostic and treatment recommendations to his or her satisfaction. The patient acknowledges that all questions asked have been fully answered by the clinician.

Potential Risks:
_____ **(Patient's or Representative's Initials)** acknowledges and accepts that there are risks to the diagnosis and treatment measures that fall within and outside the conventional standard of care and that these risks may include: unintended exacerbation of symptoms, new symptoms, allergic and other unintended injury and side effects from exercise, lifestyle modifications, dietary modifications, herbal and nutritional supplements, injected or intravenous therapies, hormonal therapies, adverse interactions with drugs, herbs and/or nutrients. The specific risks associated with the proposed procedures have been explained to the patient and/or the patient's representative.

No Guarantee of Potential Benefits:
_____ **(Patient's or Representative's Initials)** acknowledges that treatment may result in the restoration of health and optimal functional capacity, relief of pain and symptoms, injury and disease recovery, and prevention or reversal of disease or disease progression, but ALSO acknowledges that no expressed or implied guarantees or representations can or have been made by the clinician or any affiliated staff regarding the cure or improvement of the patient's condition.

Limitations of Full Disclosure:
_____ **(Patient's or Representative's Initials)** acknowledges that the clinician cannot know or anticipate and explain every possible risk or complication, and that the patient or representative willingly chooses to rely on the clinician to exercise their best judgment within the bounds of their licensure for any of the above.

Responsibility to Report Possible Pregnancy:
_____ **(Patient's or Representative's Initials)** agrees to alert the clinician should she suspect that she is or may be pregnant in acknowledgment that some of the diagnostic or therapeutic techniques could present risks to a pregnancy.

Disclosure Coverage:
_____ **(Patient's or Representative's Initials)** acknowledges and agrees that consent form will cover the entire course of treatment for the present condition and for any future condition(s) for which treatment is sought.

Willing Participation:
_____ **(Patient's or Representative's Initials)** understands that the patient is free to discontinue participation in any and all aspects of the medical care provided by the clinician at any time and that the patient or representative is responsible for informing the clinician of the adherence to or discontinuation of any and all aspects of care and that the choice to discontinue treatments may create the risk of adverse effects for which the patient or representative bears full and sole responsibility.

Clinician Collaboration:
_____ **(Patient's or Representative's Initials)** understands that the clinician may consult with preceptors, clinical student residents, and colleagues related to the care provided and that the patient or the patient's authorized representative have the right to decline their presence or involvement during any aspect of the patient's care.

Agreement to be Contacted:
_____ **(Patient's or Representative's Initials)** understand and accept that the clinician or affiliated staff may contact the patient or representative (e.g., by phone, email, voicemail, SMS text message) to consult or exchange information related to the patient's care.

Remote Consultations:
_____ **(Patient's or Representative's Initials)** at times, consultation may be provided remotely and without direct contact with the clinician. In such cases, the patient or their representative agrees to maintain direct contact with a licensed healthcare provider that is appropriate for the patient's age, gender, and known or suspected health conditions.

Medical Record Keeping and Privacy:
_____ **(Patient's or Representative's Initials)** understands that records of the health services provided will be kept for a minimum of three, but no more than ten years after the date of the last visit or consultation. The patient or representative also acknowledges that information within the record may be analyzed for research purposes and that in such case, the patient's identity (name, address, exact birth date) will be kept confidential. Otherwise, this record will be kept securely and confidentially and without release to others unless so directed by the patient or representative, or as may be required by law or as necessary for insurance claim or other payment processing.

Patient's Responsibility to Disclose Information:
_____ **(Patient's or Representative's Initials)** understands that the patient bears full responsibility for any adverse effects experienced during or after the course of treatment that were reasonably deemed to be caused or related to a deficit in the full, accurate, and timely disclosure of symptoms and other medical information to the clinician to the best of the patient's or representative's ability.

Responsibility for Payment:
_____ **(Patient's or Representative's Initials)** understands that some or all of the recommended diagnostic and treatment measures may fall outside the conventional standard of care and may not be approved or covered by the patient's insurance because the services rendered fall outside the "standard of care," and in such event, that the patient accepts full responsibility for all associated costs and fees.

Dispute Resolution:
_____ **(Patient's or Representative's Initials)** agrees that short of overt negligence or malpractice, that any complaint or dispute that arises related to the diagnosis or treatment from clinician will be settled through binding mediation in the state which the clinician is licensed.

_____	_____	_____
Patient Print Name	Signature	Date
_____	_____	_____
Patient Representative Name	Signature	Date