Autism Treatment Center of Newtown Square

Patient Informed Consent for Treatment and Therapies

Patient Name:_____Date:_____

I, _____, do voluntarily consent to receive care at the Autism Treatment Center of Newtown Square encompassing review of historical data, physical exam, laboratory tests, diagnosis and treatment by Patrick L. Elliott, D.O., F.A.C.S.

Initials _____.

I, _____, understand and have been advised that the medical team at the Autism Treatment Center of Newtown Square and Dr. Elliott practice integrative medicine/complementary medicine. Integrative medicine is defined by N.C. Gen. Stat. 90-1.1(3) as: a diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be a potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments. The National Center for Complementary and Alternative Medicine (NCCAM) at the National Institute of Health (NIH) defines complementary medicine as a group of diverse medical and health care systems that are not part of conventional medicine. For most of the treatments considered to be under the heading of complementary and alternative medicine, there are still questions about safety, efficacy, and actions that remain to be answered through well-designed scientific studies.

Initials _____.

I understand and have been advised that the treatments and therapies that are to be provided by Autism Treatment Center of Newtown Square may not have been proven effective by traditionally accepted medical studies (randomized, double blind, placebo controlled, crossover studies) for my diagnosis. **Autism Treatment Center makes no specific claims or representations that the treatments and therapies that they will be providing will be effective or cure the condition or diagnosis that I have.** I have been encouraged to consult with my primary care physician or the specialist who is primarily treating the above designated diagnosis prior to receiving treatment from Autism Treatment Center of Newtown Square. I am also aware that the Autism Treatment Center recommends that medications should not be discontinued without the consent of the prescribing physician.

Initials _____.

I further understand and have been advised that Autism Treatment Center of Newtown Square sells health care practice related items from the office. There is a potential, inherent conflict of interest when physicians sell health care practice related items from their office. Sale of practice-related items such as supplements, vitamins, minerals, and medications may be acceptable only after the patient has been told those or similar items can be obtained locally from other sources. I am fully aware that as with any product or commodity, the quality, purity, efficacy, concentration, source and numerous other variables will determine the ultimate price. I also recognize that I have the option to pursue my health care needs at any doctor's office I so choose.

Initials _____.

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I also understand and have been advised regarding possible adverse effects of all treatments and therapies that Autism Treatment Center of Newtown Square will be providing me, such as the possible adverse effects of intravenous (IV) treatments which may include, but are **not** limited to the possibility of infection, phlebitis, headaches, dizziness, hypoglycemia, electrolyte imbalance, mineral depletion, fatigue, kidney failure, or even death.

Initials_____.

I understand that only with my consent could my child be restrained for the purpose of drawing blood or providing intravenous medications. At no time will my child be restrained without my constant physical presence or left unmonitored by an Autism Treatment Center of Newtown Square medical staff member.

Initials_____.

I understand that if at any time I choose to withdraw consent for treatment, it is my responsibility to notify Autism Treatment Center of Newtown Square in writing of this change. I understand that this consent is in effect until withdrawn in writing by the consenting parties.

Initials_____.

I understand that I am responsible for payment in full for each appointment at the time of services rendered, regardless of my insurance coverage. I understand that Autism Treatment Center of Newtown Square is not enrolled in any HMOs, PPOs, POs, or any other health insurance plans. I also understand that Autism Treatment Center of Newtown Square will not bill insurance on behalf of the patient.

Initials_____.

I agree to allow an Autism Treatment Center of Newtown Square staff member to photograph my child/self for in office use.

Initials_____.

This form has been fully explained to me and I certify that I understand its contents and the purpose thereof.

_____ _____

Patient, or Parent/Guardian 1 of Minor **SIGNATURE** **PRINT FULL NAME**

_____ _____

Patient, or Parent/Guardian 2 of Minor **SIGNATURE** **PRINT FULL NAME**

I certify that this form and the procedures involved have been full explained to the above.

_____

(Witness) Autism Treatment Center of Newtown Square

Autism Treatment Center of Newtown Square
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