**Pittsburgh Alternative Health, Inc**
20 Cedar Boulevard, Suite 303
Mt. Lebanon, PA 15228
Phone 412-563-1600
Fax 412-563-2040
www.PittsburghAlternativeHealth.com

# TREATMENT CONSENT

I, the undersigned, hereby authorize Dr. Darrell S.C.S. Misak ND, RPh to perform a health evaluation upon myself which consist of health history interview and nutritional evaluation. I recognize that the state of Pennsylvania currently does not have licensure for Naturopathic Doctors, and that Darrell S.C.S Misak ND, RPh is not a licensed medical practitioner in this state. I realize that Darrell S.C.S. Misak ND, RPh can not make any diagnosis of my current health and recommend any treatments based upon such a diagnosis in the state of Pennsylvania.

I understand the nature and risk of alternative therapies and the possible complications. In addition, I understand that there is no implied or stated guaranty of success or effectiveness of any specific treatment results that may be obtained through Darrell S.C.S. Misak's services. I will be using alternative therapies as a compliment to my regular medical program, and I will not discontinue any medication or treatment without the approval of my existing doctor.

I hereby certify that I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies, or on a mission of entrapment or investigation. I will disclose this information to Darrell S.C.S. Misak ND, RPh prior to service if this is the case.

I also understand that any services provided by Darrell S.C.S. Misak ND, RPh will not be reimbursable by any insurance company, due to Darrell S.C.S. Misak's non-licensed medical status. I understand that I will be responsible for payment in full at the time of service.

I understand that I am free to withdraw my consent and to discontinue participation in Darrell S.C.S. Misak's therapies at any time.

Name (please print):_____

Signed:_____ Date: _____

Witnessed by:_____ Date: _____

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# FINANCIAL CONSENT

I, the undersigned, understand that I am responsible and expected to pay at the time services are rendered and/or goods are received, unless prior financial arrangements have been made. I also understand that any services provided by Darrell S.C.S. Misak ND, RPh will not be reimbursable by any insurance company, due to Darrell S.C.S. Misak's non-licensable status in the state of Pennsylvania. Therefore, I also understand that Pittsburgh Alternative Health, Inc. will not process or assist in any claims, insurance or medical billing. I understand that it is my sole financial responsibility to Pittsburgh Alternative Health, Inc. for all charges incurred.

I also understand that Pittsburgh Alternative Health, Inc., the office of Darrell S.C.S. Misak, N.D., RPh., has the right to access a cancellation charge to my billing information for missed appointments or appointments cancelled with less than a 24 hour notice.

Name (please print):_____

Street: _____

City: _____ State: _____ Zip: _____

Phone (Daytime): (____)_____ Evening: (____)_____

Patient Signature:_____ Date: _____

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# INFORMED CONSENT AGREEMENT FOR SENSITIVITY (Electro-Dermal) ASSESSMENT

Patient Name:_____ Telephone: (____)_____
Address:_____ City:
_____Zip Code:_____

I desire to be assessed to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the assessment procedure to be used is not generally employed by the majority of physicians for this purpose.

I choose to be assessed using an electro-dermal technique via a Biomeridian® testing device. I also understand that electro-dermal assessment has not been scientifically proven to be reliable, and that my physician must still rely upon personal observations and history as to the efficacy of the assessment and balancing technique.

I understand that other methods of sensitivity assessment are available and these have been described to me.

I understand that I may decline to participate in the electro-dermal assessment and can choose instead to have other sensitivity assessments with my own personal physician.

I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies, or on a mission of entrapment or investigation.

I have been provided with the opportunity to ask any pertinent questions I have regarding this assessment and balancing technique.

I understand that the Pennsylvania Medical Association does not currently find demonstrated scientific basis for this assessment technique, and this test therefore is not recognized as reimbursable by any insurance company.

I understand that I am responsible for payment of the normal and necessary fees associated with my assessment and balancing.

IN WITNESS WHEROF, I have executed the foregoing this ____ day of _____, 200__.

Name (please print):_____

Signed:_____ Date: _____
if under 18 years of age, Parent or Guardian must also sign)

Witnessed by:_____ Date: _____