



## INFORMED CONSENT FOR LIVE BLOOD MICROSCOPY (LBM)

All Clients: Please Initial Each Statement

I understand and agree:

\_\_\_\_\_ That Pittsburgh Alternative Health, Inc., is a member of a private group Coalition for Health Education and I agreed to become a member of the Coalition for Health Education for educational awareness of what a Live Blood Microscopy Evaluation and Pittsburgh Alternative Health's viewpoint on health entail.

\_\_\_\_\_ That Pittsburgh Alternative Health, Inc., does not treat, diagnose, cure, or prevent any known medically diagnosed condition, nor do I expect to receive a diagnosis of any condition based on the educational findings of my Live Blood Microscopy Evaluation.

\_\_\_\_\_ That the viewpoints of Pittsburgh Alternative Health, Inc., do not necessarily agree with the accepted health viewpoints, naturopathic or traditional, of modern civilization, and any recommendations are not meant to replace, slander, condemn, or suggest that current accepted viewpoints are wrong or harmful.

\_\_\_\_\_ That I am financially responsible at the time of service for my Live Blood Microscopy Evaluation, and that Pittsburgh Alternative Health, Inc., does not bill insurance, nor does any insurance company cover any services offered at Pittsburgh Alternative Health, Inc.

\_\_\_\_\_ That any recommendations made by Pittsburgh Alternative Health, Inc., based on the observations seen during my Live Blood Microscopy Evaluation are not considered treatment, but instead, my choice to follow based on informed consent and a different educational perspective.

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*\*\*For clients 18 or under, the signature & attendance of the parent or guardian for insertion is required\*\*\*

I have reviewed this form with my client. Therapist Signature: \_\_\_\_\_