Deborah Manke, HNP Functional Medicine
Holistic Practice, Adult Primary Care, Acupuncture Detoxification

Consent for Medical Services

Patient's Legal Name

_____

Date of Birth: _____ Age:_____

Preferred Name_____

Sex: __ M__ F Marital Status: _____

Address:_____

City: _____ State: _____ Zip:_____

Phone: _____ Cell: _____

Email: _____

Where did you hear about us?

_____

Medical Insurance Carrier/Company:

_____

PATIENT and Medical Practitioner of DEBORAH MANKE, HNP FUNCTIONAL MEDICINE (PROVIDER) hereby enter into this agreement for provision of medical services specified herein ("Service"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PROVIDER agree as follows:

1) The PATIENT acknowledges and agrees that this agreement has been entered into before the PROVIDER has provided the services specified herein to the PATIENT.

2) The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.

3) The PATIENT acknowledges reading and receiving a copy of the Notice of Privacy Practices provided by DEBORAH MANKE, HNP FUNCTIONAL MEDICINE, and by signing this agreement, the PATIENT authorizes DEBORAH MANKE, HNP FUNCTIONAL MEDICINE and its representatives to use and share PATIENT health information as described in the Notices of Privacy Practices.

4) The services provided to the PATIENT may include: a) Evaluation of patient medical history, lifestyle, imaging, and laboratory test results; b) Physical Examination and diagnostic tests; c) Providing medical recommendations or management for disease prevention and healthy aging, including advice regarding nutrition and nutritional supplementation, exercise, healthy lifestyle changes, stress management, hormone-balancing, and replenishment therapy, functional medicine, and prescription of preventive-aging, restorative medical therapies, as indicated by a medical history, physical examination and laboratory parameters/testing. d) Detoxification Management including auricular acupuncture, e) Other services such as Therapeutic touch, intravenous therapy, Bemer, Biomat, PEMF therapy

5) The PATIENT agrees to be responsible for the Services. All costs including practitioner services are to be paid in full by the PATIENT to the PROVIDER at the time services are rendered. PROVIDER cannot assure the PATIENT that their insurance company will reimburse for any of primary care medicine, holistic nursing, functional medicine, preventive medical services or related therapies.

_____ Date: _____

Patient Signature