Label

Consent for Care at CMB Health Specialties

I, _____, have sought health care from Carol M. Brown, DO, PhD, FAARFM, ABAARM. I have chosen to do this of my own free will. I understand that Dr. Brown is board certified, practices Integrative Medicine and is licensed in the states of Wisconsin and Illinois.

Everyday medicine, commonly practiced in the United States, is a system using pharmaceuticals, procedures and surgery as primary modes of therapy. Integrative Medicine is a system that *combines* conventional medicine with nutrition, exercise and naturally derived interventions such as herbs, vitamins, minerals, enzymes, etc. to improve health. Because Dr. Brown is trained and licensed in both systems, I believe she is qualified to determine whether the use of every day medical treatments or integrative medicine would be in my best interest. I understand she may refer me to other specialists for support and opinions. If I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to ask questions and/or to seek the opinions of other physicians.

I realize that Dr. Brown's integrative approach to health care is not as unilateral as pharmaceutical or surgical therapy, that it may involve various interventions and that it requires my understanding and involvement.

I understand that many medical authorities consider Integrative Medicine to be unproven, ineffective, and even unsafe. I also understand that because every individual is inherently unique, Dr. Brown cannot guarantee that her treatment program will result in resolution of a condition (nor can any other physician provide such a guarantee).

I understand that blood may be drawn from me and the lab will bill my insurance for HIV testing without further permission being given by me if a doctor, other health professional, or employee is exposed to my blood or bodily fluid.

I am consulting with Dr. Brown solely for reasons concerning my own health. I am not consulting with Dr. Brown in order to provide any information to any enforcement, regulatory, disability, or investigative agency of any kind.

By my signature below, I certify that I have read and understand the above. I hereby do voluntarily consent to such care including routine procedures, examinations, routine and advanced tests, or local anesthesia and other treatment by CMB Health Specialties professionals and their assistants, appointees, or consultants as is necessary in their judgment.

Signature: _____ Date:_____

I, Carol M. Brown, DO, PhD, FAARFM, ABAARM consider it a privilege and an honor to be a physician to_____, and I promise to provide him/her the best medical care that I am capable of, in the safest, least toxic and most cost effective way that I know. I promise to listen carefully to needs and desires, and to treat with dignity and respect. I promise to stay knowledgeable and current in my profession, and to focus my attention not only on the presenting complaints, but also on preventive measures to maintain good health in the years to come.

Signature: _____ Date: _____