Vital Well-Being Center, Inc.

210 S. Pinellas Ave., Suite 106
Tarpon Springs, FL 34689

727-786-1661 Office
727-785-3783 Fax

Patient General Consent

I understand that this practice is different from other conventional medical practices. The doctors at this office have special training in areas of natural healing. These include nutrition, exercise and stress management techniques which work alongside the bodies own natural healing processes. I understand that natural supplements, procedures and medications may be prescribed from time to time when deemed appropriate for my condition; and I agree to take these items as directed.

I understand that I am forming a therapeutic partnership with the doctors here at the Vital Well-Being Center, Inc. and that the results I can expect are dependent upon the strength of that partnership along with the level of effort I put into my end of the agreement. If there is information that I have withheld from the doctor, or if there is some reason as to why I cannot complete the treatment program that has been created for me, I will notify the office so that we may correct this oversight and modify my program at the next visit. Likewise, I can expect that my questions and suggestions will be met with an open-minded and respectful attitude by the physician and staff at the Vital Well-Being Center, Inc.

I understand that the Vital Well-Being Center, Inc. is not a primary care practice. If I should become ill when the office is closed, I will seek help at the nearest emergency facility and contact the Vital Well-Being Center, Inc. at my earliest opportunity to inform my doctor of any new development. If hospitalization is required, I understand that the physician at the Vital Well-Being Center, Inc. do not carry admitting privileges. It is highly recommended that I maintain a relationship with a primary physician in the event that hospitalization is needed. It is the duty of the primary care physician to make sure that all required screening tests, such as pap smears, mammograms, stress tests, colonoscopies, etc. are ordered and a full physical exam is completed annually.

I understand that some of the treatments suggested for me are currently unproven and experimental. Although recommended based on knowledge and scientific reason, I understand that some of these treatments are not standard of care throughout the medical community at large and that other physicians may not be familiar and may disagree with them. I have been informed of this and based on the information provided to me, am willing to accept these risks. I will be allowed the opportunity to ask questions and research any treatment suggested before agreeing to it. I also understand that the physicians have done their research as well, including (in many cases) receiving these treatments themselves. If these treatments are discussed with my primary care physician and he/she disapproved; our physicians will be willing to discuss these therapies with other providers.

Patient Name: _____

Patient Signature: _____

Date: _____