

Consent for Care Provided by Dr. Mels (the Future Doctor) and Clinical Team

I understand that services provided by Dr. Mels (the Future Doctor) may involve care delivered by a collaborative clinical team, which may include qualified clinical interns, licensed professionals, and affiliated practitioners. In such cases, care may be provided under the supervision of a licensed or credentialed healthcare provider.

I understand that:

- One or more clinical student interns may participate in my care, under the supervision and direction of a qualified supervisor (e.g., a licensed nutritionist or other healthcare provider).
- My medical history, treatment plan, and progress may be discussed by supervising clinicians to ensure the appropriateness and effectiveness of the care provided to me.
- This consent applies to Dr. Mels (the Future Doctor) and any other affiliated clinicians or team members currently involved in my care, as well as those who may be involved in the future.

I understand that all members of the care team are expected to uphold standards of confidentiality and professionalism in accordance with applicable laws and regulations.

Client Name (Printed): _____

Client Signature: _____

Date: _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

If Client is a Minor or Dependent:

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Consent for Clinical Herbs and Dietary Supplements

Use of Therapeutic Substances

I understand that my clinician may recommend the use of therapeutic substances, which may include herbs, minerals, vitamins, amino acids, and animal-derived materials. These substances may be provided in various forms such as teas, capsules, powders, tinctures (which may contain alcohol), topical applications, suppositories, or other delivery methods.

Purpose and Acknowledgment of Risks

I acknowledge that the goal of clinical herbal medicine is to enhance the body's

natural healing ability, promote vitality, and support balance within the body. These substances are not intended to diagnose, treat, or prevent any disease. Although generally well-tolerated, I understand that herbs and dietary supplements may occasionally cause side effects. These can include, but are not limited to, digestive disturbances, skin rashes, headaches, or, in rare cases, allergic reactions.

I agree to immediately notify my clinician of any unexpected or adverse reactions I experience while using these products.

Product Quality and Source

I understand that Dr. Mels (the Future Doctor) recommends purchasing herbs and supplements from their online shop to ensure product quality and safety. I acknowledge that the quality of products purchased from outside sources may be unknown and could pose additional risks.

Potential Herb–Drug Interactions

I am aware that while most herbs do not significantly interact with prescription medications, there are exceptions. Some herbs may affect the action of certain pharmaceuticals, particularly drugs that have a narrow therapeutic range or require careful dosage control.

I accept responsibility for disclosing all medications I am currently taking, including over-the-counter drugs, other herbs, and supplements, to both my clinician and my primary healthcare provider.

If I observe any changes in the effectiveness or side effects of my medications while taking herbal products, I will report this immediately to all relevant healthcare professionals.

I understand that I should discontinue use of all herbal supplements at least 48 hours prior to any surgical procedure. I also agree not to take herbs while using anticoagulants, antiepileptic drugs, or digoxin unless I have received appropriate expert guidance.

Toxicity and Dosage Safety

I understand that the herbs recommended by my clinician are generally considered safe and non-toxic when used as directed. However, I recognize the importance of taking these substances only at the dosages prescribed to me.

I understand that the liver and kidneys are particularly sensitive to substances taken internally, and I agree to inform my clinician of any current or past conditions related to these organs.

I also acknowledge that herbs should not be used during pregnancy or breastfeeding without the supervision of a board-certified OB-GYN (M.D. or D.O.). If I become pregnant, I will stop taking all herbal supplements and seek appropriate medical advice before resuming their use.

Informed Consent

By signing this form, I confirm that I understand the information provided above. I agree to:

- Take herbs and supplements only as recommended by my clinician.
- Inform my clinician of all medications, supplements, or herbs I am currently using.
- Notify my clinician of any past or present liver, kidney, or other relevant health conditions.
- Immediately report any unexpected or adverse reactions to herbs or supplements.
- Communicate with my healthcare providers about any herbal products I am using.
- Discontinue use of herbs in the event of pregnancy, surgery, or prescribed medications with known interactions, unless otherwise advised by a qualified medical professional.

Client Name (Printed): _____

Client Signature: _____

Date: _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

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Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Consent Form: Nutrition Counseling and Dietary Supplementation

Purpose and Scope

I understand that nutrition counseling with Dr. Mels (the Future Doctor) is intended to support my overall health and wellness. This may include therapeutic nutrition, dietary advice, lifestyle modifications, the use of whole foods, and dietary supplements. These recommendations are made to help me achieve optimal health and meet my personal wellness goals.

Therapeutic Nutrition and Dietary Supplements

I understand that dietary recommendations may include the use of nutritional supplements such as, but not limited to:

- Vitamins
- Minerals
- Herbs and botanicals
- Amino acids
- Fatty acids
- Animal-derived substances

These may be delivered in various forms, including teas, pills, powders, tinctures (which may contain alcohol), topical applications, suppositories, or other methods deemed appropriate by Dr. Mels (the Future Doctor).

Potential Risks and Side Effects

I understand that while side effects from nutritional supplements and herbal remedies are not common, they can occur. These may include, but are not limited to:

- Headaches
- Skin rashes or irritation
- Digestive upset (e.g., nausea, diarrhea, bloating)
- Allergic reactions (particularly in individuals sensitive to certain substances)

In most cases, side effects resolve quickly if the supplement is reduced or discontinued. I agree to immediately notify Dr. Mels (the Future Doctor) of any unexpected or unpleasant side effects I experience while taking any recommended supplement.

Nutritional Evaluation and Testing

I understand that any nutritional evaluations or testing offered through Dr. Mels (the Future Doctor)' services are not intended to diagnose or treat disease. These evaluations are intended to support the development of a health-promoting plan tailored to my needs, and to help track my progress toward personal wellness goals.

Drug–Nutrient Interactions

I understand that some dietary supplements may interact with prescription medications. Although clinically significant interactions are rare, they are possible, especially with medications that have a narrow range of safe dosage (e.g., anticoagulants, antiepileptic drugs, digoxin).

I agree to:

- Fully disclose all medications, including over-the-counter drugs and other supplements, to Dr. Mels (the Future Doctor).
- Inform my physician or healthcare provider of any supplements I am taking.
- Report any suspected interactions or changes in how my medication affects me to both Dr. Mels (the Future Doctor) and my physician.
- Consult with a physician before continuing supplement use if I am scheduled for surgery or am prescribed medications with known interaction risks.

Safety and Toxicity

I understand that all supplements recommended by Dr. Mels (the Future Doctor) are generally considered safe and non-toxic at recommended dosages for most individuals. However, it is my responsibility to:

- Follow the recommended dosage instructions carefully.
- Disclose any history of liver or kidney disease, as these organs are particularly sensitive to ingested substances.
- Inform Dr. Mels (the Future Doctor) of pregnancy, breastfeeding, or plans to become pregnant. I understand that supplements should not be used during pregnancy or lactation unless directed by a qualified healthcare provider.

I agree to notify Dr. Mels (the Future Doctor) of any relevant changes to my health status, including but not limited to:

- Pregnancy or lactation
- Diagnosed health conditions (especially liver or kidney conditions)
- New medications or supplements
- Scheduled surgeries

Acknowledgment and Consent

By signing below, I acknowledge that:

- I have read and understand the information above.
- I have had the opportunity to ask questions.
- I voluntarily consent to receive nutrition counseling and recommendations for dietary supplements from Dr. Mels (the Future Doctor).
- I understand that I am responsible for communicating with all members of my healthcare team about any dietary supplements I choose to take.

Client Name (Printed): _____

Client Signature: _____

Date: _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

If Client is a Minor or Dependent:

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Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Consent Form: Medical Treatment Acknowledgment

Medical Responsibility and Coordination of Care

I understand that it is my responsibility to provide complete and accurate information about my health history on the Health History Questionnaire or Intake Form, including any updates or changes to my health status since my last visit or service with Dr. Mels (the Future Doctor).

I agree to inform Dr. Mels (the Future Doctor) of:

- Any new symptoms, medical conditions, or diagnoses
- Any worsening of existing health concerns
- Any changes to my medications, supplements, or treatments

I understand that if I experience a new or worsening condition, I am advised to consult with a licensed physician or other appropriate healthcare provider.

If I am currently receiving medical care from a physician, I understand that I should continue under that physician's care for as long as I and my physician determine it is necessary.

Diagnosis and Treatment of Disease

I understand that the services provided by Dr. Mels (the Future Doctor), including nutrition counseling and wellness support, are not intended to diagnose, treat, or cure any disease. These services are designed to complement—not replace—conventional medical care.

I understand that:

Dr. Mels (the Future Doctor) does not recommend altering or discontinuing any prescribed medications, treatments, or therapies without first consulting my primary care physician or healthcare provider.

All decisions related to medical treatment, medication, and disease management should be made in collaboration with my licensed healthcare providers.

Acknowledgment and Consent

By signing below, I acknowledge that:

- I have read and understood the above information.
- I agree to communicate openly with Dr. Mels (the Future Doctor) regarding any health changes.
- I recognize the importance of continuing care with my physician for any medical diagnosis or condition.
- I understand that services provided by Dr. Mels (the Future Doctor) are intended to support my overall wellness and are not a substitute for medical diagnosis or treatment.

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Practitioner Signature: _____

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Parent/Guardian Signature: _____

Relationship to Client: _____

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Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Consent Form for Services with Dr. Mels (the Future Doctor)

Voluntary Consent for Services

I hereby voluntarily request and consent to receive services from Dr. Mels (the Future Doctor), including but not limited to nutrition counseling, wellness education, and any related support services.

I understand that:

- I have not been guaranteed any specific outcomes regarding the use or effectiveness of any services provided.
- I am free to discontinue any or all services at any time without penalty.
- I voluntarily assume all risks inherent in the nature of these services.

I waive and release all claims, costs, liabilities, expenses, and judgments against Dr. Mels (the Future Doctor) and her affiliates, including staff, representatives, and contractors, arising out of or related to the services I receive.

Cancellation Policy

I understand that:

- I am responsible for notifying Dr. Mels (the Future Doctor) at least 1 business day in advance if I need to cancel or reschedule an appointment.
- If I fail to provide at least 1 business day's notice, I may be charged a cancellation fee.

Insurance and Financial Responsibility

I understand that:

- Dr. Mels (the Future Doctor) does not bill insurance, and third-party payers (including Medicare, Medicaid, or private insurance) are not required to reimburse me for services.
- Fees may be eligible for payment through a Flexible Spending Account (FSA) or Health Savings Account (HSA), but I am responsible for confirming eligibility with my insurance provider.
- I am financially responsible for full payment at the time of service.

Fees for Returned Checks and Late Payments

I understand that:

- I am responsible for any returned check fees, as well as any unpaid service fees.
- If I do not pay for services at the time they are rendered or within 30 calendar days, I may incur additional late fees.
- I may request a current fee schedule at any time, which includes service fees, cancellation fees, late fees, and returned check fees.

Telehealth Services

I understand that Dr. Mels (the Future Doctor) may provide services via telehealth, which involves the secure transmission of video, audio, photographs, and/or health information to deliver care.

I acknowledge and understand the following:

- Telehealth is not the same as in-person care.

There may be limitations, including the inability to:

- Perform hands-on physical exams (e.g., listen to heart or lungs)
- Fully interpret body language, vocal tone, or other physical cues

- Provide emergency physical care if needed
- Technical issues may arise that could interrupt or compromise the session

There is always some risk that communications could be:

- Overheard
- Unsecured
- Accessed by unauthorized third parties

Despite these risks, I understand that:

- I have the right to refuse or stop telehealth services at any time
- I may request an in-person appointment, though it may not be available at the same time or location
- I will be informed of any other individuals present (seen or unseen), and I may choose to exclude them from the session
- I must inform Dr. Mels (the Future Doctor) if anyone else is present with me during the session
- I will have access to my records from telehealth services, in accordance with applicable law
- Benefits of telehealth include increased access, flexibility, and reduced exposure to illness

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Date: _____

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Practitioner Signature: _____

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Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Confidentiality and Electronic Communication

I understand that all confidentiality protections required by law apply to the services I receive, including telehealth.

However, I acknowledge that:

- Communication through text, email, telephone, or video conferencing cannot be guaranteed to be fully secure
- There is a risk that such communication may be intercepted or accessed by third parties

To help maintain confidentiality, I agree to:

- Participate in sessions from a private location where I cannot be overheard

- Not record any session without written permission from Dr. Mels (the Future Doctor)
- Not post any part of a session online or share it publicly without explicit written consent

Acknowledgment and Consent

By signing below, I acknowledge and agree that:

- I have read and understand the terms of this consent form
- I have had the opportunity to ask questions, and all questions have been answered to my satisfaction
- I understand my rights and responsibilities regarding the services provided by Dr. Mels (the Future Doctor)
- I voluntarily consent to receive services from Dr. Mels (the Future Doctor) under the conditions outlined above

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Client Signature: _____

Date: _____

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Practitioner Signature: _____

Date: _____

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Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Emergency Situations and Telehealth Limitations

I understand that telehealth services are not appropriate for emergencies or crisis situations. If I am experiencing a medical or mental health emergency, I agree to:

- Call 911 immediately or go to the nearest emergency room.
- If an emergency arises during a telehealth session, I will call 911 and, if possible, remain connected via video until emergency responders arrive.

I understand that Dr. Mels (the Future Doctor) is not an emergency service provider, and telehealth should be used only for non-emergency wellness care and consultations.

Consent to Care and Telehealth Services

By voluntarily signing below, I confirm that:

- I have read, or have had read to me, and understand the Consent to Services with Dr. Mels (the Future Doctor), including information regarding in-person and telehealth services.
- I have been informed of, and understand, the benefits and risks associated with receiving services from Dr. Mels (the Future Doctor).

- I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

I understand that this consent applies to the entire course of treatment for my current condition(s) as well as any future condition(s) for which I may seek care from Dr. Mels (the Future Doctor).

Client Name (Printed): _____

Client Signature: _____

Date: _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

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Parent/Guardian Signature: _____

Relationship to Client: _____

Client Name (Printed): _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

Scope of Services and Medical Disclaimer

I understand and agree that my consultation with Dr. Mels (the Future Doctor) is not a medical consultation with a licensed medical doctor or physician, and that Dr. Mels (the Future Doctor) does not hold a medical doctorate (M.D. or D.O.).

I acknowledge that:

- The information and services provided during my consultation are based on traditional herbal practices and nutritional principles, and are intended for educational and wellness support purposes only.
- This consultation does not diagnose, treat, cure, or prevent any disease or medical condition.
- Dr. Mels (the Future Doctor) does not prescribe pharmaceutical medications or perform any medical procedures or treatments.

I have been advised to consult with a licensed healthcare provider before beginning any new health, dietary, or supplement regimen—especially if I:

- Have a known medical condition
- Am pregnant or breastfeeding
- Am taking prescription medications

I understand that it is my responsibility to make informed decisions regarding my health and to involve my licensed medical providers in those decisions as appropriate.

Client Name (Printed): _____

Client Signature: _____

Date: _____

Practitioner Name (Printed): _____

Practitioner Signature: _____

Date: _____

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Date: _____