INFORMED CONSENT FOR CARE

_____I understand that Root Causes Holistic Health and Medicine LLC (Herein after referred to as Root Causes) is an Integrative Medicine practice focusing on whole body health and wellness through the use of naturally occurring compounds as much as possible, and pharmacologic interventions when necessary and in the best interest of the client. Integrative Medicine is personalized care that blends conventional medicine with evidence-based complementary/integrative therapies. Recommended therapies may include, but are not limited to, nutraceuticals, traditional prescription medication, mind-body modalities such as meditation, yoga, and guided imagery, biologically based therapies such as vitamins, herbs and other supplements in oral, injectable and intravenous forms, MESO therapy, PRP , injections of various prescriptive compounds for therapeutic purposes, nutritional recommendations, exercise recommendations, other systems of medicine-based therapies such as homeopathy, light therapy, laser therapy, and oxygen therapies including hyperbaric, ozone insufflation and intravenous ozone.

_____Individualized Care plans are evidence-based, safe and custom-designed to meet the patient's needs and goals. Evidence base changes frequently for Integrative Medicine and recommendations are done with the evidence base currently known to the practitioner at the time of your consultation. These recommendations will very likely not be what is considered to be the medical/legal "standard of care". Your primary care practitioner is likely the person you will want to see for "standard of care" protocols. Root Causes never recommends stopping conventional medical treatment or Care that is in your best interest. Please retain your medial team.

_____I understand that Doreen DeStefano is an Advanced Practice Registered Nurse with a **Doctorate in natural health and a Doctorate in nursing practice. She is not Medical Doctor.** The Medical Director for Root Causes Barry Butler MD.

_____An integrative medicine consultation may include, but is not limited to: Individualized consultation that may include evaluation of lifestyle, nutrition and supplements/ vitamins/herbs, bio-identical hormone, individualized Care protocols for your specific concerns, lab testing of blood, sputum, stool or urine, a physical examination and referral to other therapeutic providers for care not provided by Root Causes. Many modalities are not "standard of care" as legally defined.

_____ I understand that services at Root Causes are **not covered by insurance**. I understand that Root Causes does not accept insurance nor does Root Causes provide billing codes to submit claims to insurance. I understand that I, _____ am responsible for payment at the time of service. Payment accepted is in the form of cash, check, or credit card.

_____I understand that lab studies conducted on my behalf confer a professional responsibility to the practitioner, and therefore require interpretation and follow up. Lab slips require diagnostic codes and

interpretation. Therefore, lab slips are not given without an appointment to determine a medical diagnosis/necessity, and a lab review appointment to review and interpret results. The cost of lab studies is never included in the price of your visit. Billing for labs is between you and the company performing the service.

_____I understand that I have the right to choose which recommendations to incorporate into my Care plan and that I should always communicate any new therapies, including vitamins, herbs, and supplements to my entire healthcare team.

_____I understand that Root Causes implies no guarantee of the outcomes/results intended from any Care and/or recommendations provided to me, and that I have the right to choose my Care plan and that I may refuse any or all Care suggestions at any time. There are no guarantees that your condition will improve or resolve and none have been given to me by Doreen DeStefano or any of her personnel regarding cure or improvement of my condition.

_____ I understand that not following the entire protocol recommended to me may affect the results of my Care plan and that I may not achieve the stated goals if the protocol is not followed.

_____I acknowledge that I have not been asked to stop/discontinue care provided by my specialty or primary care medical teams.

_____ I understand that this is a fee for service practice and that consultation fees **may be up to** $895.00 depending on the complexity of your case. Payment is expected at the time of service.

_____ I understand and hereby agree that neither Root Causes nor it's employees, officers, directors, shareholders, successors and assigns (the "released parties") may be held liable or responsible in any way for any injury, death, or other damages to me or my family, heirs or assigns that may occur as a result of my Health care at Root Causes, or as a result of product liability or the negligence of any party, including the Released parties, whether passive or active.

_____ I agree not to be under the influence of alcohol or any drugs while under care at Root Causes.

_____ I hereby personally assume all risks in connection with my health care for any harm, injury, or damage that may befall me while as a result, including all risks connected therewith, whether foreseen or unforeseen.

_____ I further save and hold harmless said activity and Released Parties from any claim or lawsuit for personal injury, property damage, or wrongful death by me, my family estate heirs or assigns arising out of my actions or inactions.

_____ I further declare that I am of lawful age and legally competent to sign this liability release, or that I have acquired the written consent of my parent or guardian.

_____I understand the terms herein are contractual and not mere recital, that this instrument is a legally binding document and that I have signed this document of my own free act.

I, _____, by this instrument do hereby exempt and release Root Causes Holistic Health and Medicine LLC, Inc, and all related parties and defined above, from all liability or responsibilities whatsoever for personal injury, property damage, or wrongful death, however

caused, including but not limited to product liability or the negligence of the released parties, whether passive of active.

_____ I understand that all sales are final for ALL products and services. No refunds shall be granted. I understand that once supplements have left the building, Root Causes is unable to accept returns. I have carefully considered my options and responsibilities and understand that I am welcome to ask questions about products or services and I am responsible for payment for products and services.

_____I understand all the facts given to me in this form. I give my consent to Doreen DeStefano and Root Causes provide Integrative Medicine initial consultation and follow up services. I attest with my signature below that Doreen DeStefano has discussed all the information on this form, that I have had the chance to ask questions and that all of my questions have been answered and I want to continue with consultation and other services as deemed necessary or prudent.

_____ I hereby acknowledge that I understand that my Insurance coverage, including Medicare, will not pay for this Non-covered service, and that all services ancillary to this Care may also be Non-covered services and Non-reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

_____ I acknowledge that Root Causes has a 24 hour cancellation policy. If it is necessary to cancel my appointment, I will do so with more than 24 hours' notice. I acknowledge and give my permission that on the third time I cancel within 24 hours, or do not show up for my appointment, Root Causes will charge my credit/debit card the full amount of the scheduled visit.

_____ I understand that all goods and services purchases are final. In case of a dispute of charges, I authorize all medical information to be released to all credit card companies or other parties. I agree to pay Root Causes for service fees and costs for processing any disputes.

Patient's Name (Please print)_____

Signature of patient:_____ Date:_____

Signature of Provider:_____ Date:_____