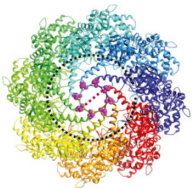
Dr Jacquie NMD
Dr Jacqueline Carboni Greenfield, Naturopathic Physician
CAREFREE REGEN MEDICAL
Contact 480.284.5240.



GENERAL CONSENT TO NATUROPATHIC & CHINESE MEDICINE: ASSESSMENT, ADVISE AND TCM TREATMENTS

I, _____ , request Dr Jacqueline Greenfield NMD to provide me with the Naturopathic and Chinese medical approach to aid in the treatment of my condition, _____ , and to assist me to create my preventative wellness program. Dr Jacqueline Greenfield is a naturopathic medical doctor, licensed by the State of Arizona Statutes A. R. S. Chapter 14, section 32-1501. In Arizona, she is licensed as a primary care physician with the right to perform minor surgery, spinal and joint manipulation and soft tissue mobilization, physical therapy, acupuncture, moxabustion, electrical stimulation, homeopathy, intravenous nutrition, prescribe pharmaceuticals, nutraceuticals and herbs, provide counseling and education. She holds a NCCAOM Board Certification in Oriental Medicine.

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I know that alternative care is not meant to replace conventional medical care and that I should continue to see my own medical doctor or request that I also receive integrated conventional medical attention from Dr Greenfield. I acknowledge the use of Telemedicine and accept treatment and prescriptions based on the assessment obtained during the virtual visit and waive a physical exam at this time. I hold Dr Greenfield harmless from any claims for injuries or illness that may occur and I take full responsibility for my participation in any of the aspects of the protocols and treatments used. I verify that I understand the HIPPA policy provided and the information I have been supplied is correct to the best of my knowledge.

I understand that Dr Greenfield does not accepts insurances. I hereby acknowledge that I have been told, prior to receiving treatment, that payment is due in full at the time of services for all charges.

I understand that any lab charges (including pathology services performed by my physician or another physician) are separate from the charges for my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments. By signing this form as Patient/Guardian/Agent/or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service are due and payable by me at the time of services.

Full disclosure summary, each patient is advised as to the importance of consulting with a licensed physician regarding the patient's condition and shall keep on file with the patient's records, a form attesting to the patient's notice of such advice. Such form shall be in duplicate, one copy to be retained by the patient, signed and dated by both the provider and the patient and shall be prescribed in the following manner:

I understand that 24 hour phone notification is required for cancellation or I will be charged for the visit. I acknowledge that supplements and care may not covered by my insurance and

prescriptions may not be covered and that I understand that some prescriptions may be available in stores of my choice.

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____
Address

_____
City/State ZipCode

_____
Home Phone Cell Phone

_____
Email