

Patient Informed Consent

Please read each paragraph and initial the bottom of each page and sign and date the last page.

Patient Name: _____ Sex: M F
Address: _____ City _____ State _____ Zip: _____
Telephone: _____ Date of Birth: _____ Age: _____

Darin Ingels, ND
2425 Post Road, Suite 100
Southport, CT 06890

I have specifically sought out the services and perspective of Dr. Darin Ingels for the way he practices Complementary and Alternative Medicine (hereto referred to as "CAM"). Dr. Ingels has explained to me and I fully understand the following:

- (a) Much of Dr. Ingels treatment being recommended is not recognized as traditional, but rather as an alternative method. CAM, like any other treatment or medication, may or may not alleviate or cure the condition for which it is offered.
- (b) Dr. Ingels feels CAM may be valuable to your health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing or treatment, as well as other testing or treatment options before deciding whether the work-up, following medical analysis and possible treatment provided by Dr. Ingels are right for you. It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated by Dr. Ingels. If after reading this form, you have any questions or concerns regarding any testing or treatment, please talk to Dr. Ingels.
- (c) The federal government, including Medicare and Medicaid and most insurance companies, do not generally pay or reimburse for vitamin, mineral or herbal supplementation provided or recommended by Dr. Ingels.
- (d) Some of the assessment methods being recommended by Dr. Ingels are not recognized as traditional, but as an alternative assessment method, specifically electrodermal screening (EDS).
- (e) The United States Food and Drug Administration (FDA) reviews the safety and effectiveness of particular drugs but does not forbid physicians to use approved medications for off label use.
- (f) Some of the treatments being offered by Dr. Ingels are not FDA approved.
- (g) Some of the formulations recommended by Dr. Ingels have never been tested by the FDA for determination of actual contents or the medical effectiveness of the formulations.
- (h) The medical/scientific proof of effectiveness/therapeutic value of some of the treatments are disputed.

Patient Initials _____

(i) While Dr. Ingels believes that CAM therapies may be beneficial to your health and well-being, the traditional medical and scientific communities often dispute the medical/scientific proof of the effectiveness or therapeutic value of the treatments. You are free to contact any medical group, physician or association on their view of any recommendations made by Dr. Ingels before you begin. Dr. Ingels believes the CAM therapies he works with are valuable and might improve your health.

(i) I may leave Dr. Ingels at any time. It was my independent choice whether to see Dr. Ingels and it is always my choice whether to continue with him. I also understand that Dr. Ingels reserves the right, at any time and without cause, to discontinue any patient due to poor compliance with Dr. Ingels recommended program or for any other reason.

I, the undersigned, have read and fully understand the above information, the elements of my informed consent, my rights and responsibilities, and hereby give consent to undergo alternative and comprehensive therapies by Dr. Ingels. Information about me and my records will be confidential; data will be stored securely and will be made available only to the persons participating in my evaluation and subsequent therapies, if any, unless I specifically give written permission unless otherwise required by law.

Signed: _____ Date: _____

Witnessed: _____ Date: _____