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REQUEST AND CONSENT FOR PARTICIPATION IN THE HOLISTIC MEDICINE PROGRAM

I consent and request to participate in the HOLISTIC MEDICINE Program. HOLISTIC MEDICINE is an art of healing involving the evaluation and treatment of the body, mind and spirit, using a program that is specifically tailored to re-establishing balance in the body. Modalities may include, but are not limited to, conventional (standard) diagnostic testing and treatment, special (non-covered) diagnostic testing, special diets, special supplements, herbs, acupuncture, yoga, energy medicine techniques, ayurvedic and Chinese medical treatments, mind-body techniques such as meditation, hypnosis, journaling, and breathing exercises.

I have been advised to discuss the risks and benefits of HOLISTIC MEDICINE with my doctor(s) and other health care practitioner(s), especially if I have any questions about participation. I understand that I am expected to continue my usual medical care. I understand that the HOLISTIC MEDICINE Program will not replace, substitute for, or provide the routine medical care that should be provided by my primary care physician. I understand that I might be referred back to my primary care physician if the HOLISTIC MEDICINE evaluation suggests an underlying medical condition that requires further conventional and/or urgent medical evaluation and treatment.

I recognize that significant sickness or even death could occur as a remote but real possibility of this therapy which alters function of the body, mind or spirit. I am also aware that HOLISTIC MEDICINE may mask an underlying condition or retard a more exact diagnosis where conventional or standard therapy(ies) may be known to be indicated.

Contra-indications for HOLISTIC MEDICINE may include but are not limited to pregnancy, active chemotherapy and active treatment by another provider. I will inform my treating physician if any of these conditions exist.

Certain medications or social habits are known to affect the potential results of HOLISTIC MEDICINE and these include alcohol, tobacco, steroids or narcotics. I will inform my treating physician of use of any such substances.

The undersigned understands the hazards and potential dangers involved in treatment by means of HOLISTIC MEDICINE. The nature and consequences of the above treatment have been fully explained, and the undersigned is convinced that the treatment is in the best interest of the patient, but that no guarantee of results has been made. I understand that I may withdraw this consent at any time.

I understand that it usually requires a series of treatments to significantly change my condition. I have discussed the charges and have made payment arrangements to complete this series of treatments.

NOTICE OF NON-COVERAGE: Most (if not all) insurance companies (such as Medicare, Medical Assistance, HMO's, etc.) will not cover some or all of the services that this HOLISTIC MEDICINE Program provides. As such, I understand and agree to be personally and fully responsible for payment for such non-covered services, or the non-covered portion of such services. I understand that there are Holistic Membership and Program fees for services that are not covered, and that such fees can not be submitted for reimbursement by my carrier.

RESPONSIBILITY AND RELEASE FOR PARTICIPATION IN HOLISTIC MEDICINE PROGRAM

I understand that I have certain responsibilities in participating in the HOLISTIC MEDICINE PROGRAM. These include, but are not limited to: providing a complete and honest history, following through on recommended tests and treatments, returning for follow-up visits as scheduled, abiding by the practice policies and procedures, recognizing the limits of my health insurance plan, and advising my other health care practitioners of my participation in this program.

In consideration of my being able to participate in this program, I agree to release all liability and to indemnify Michael Cheikin MD, Wyndmoor Rehabilitation Associates PC, Wyndmoor Physical Medicine Group PC, the Plymouth Meeting Center for Optimum Health LLC, and their respective affiliated companies, including the owners and operators of the facility in which these services will be provided, their officers, directors, shareholders, agents including independent contractors, employees, representatives and their successors and assigns, from and against all claims, actions, judgment, cost, expenses and demands with representatives and their successors and assigns, from and against all claims, actions, judgments, cost, expenses, and demand with respect to injury, loss, death or damage to my person or property in connection with my taking part in the above stated program. It is understood and agreed that this release is to be binding on myself, my heirs, executor, administrators and assigns.

I certify that I have read the above and understood it. Intending to be legally bound hereby, I make this agreement.

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Patient's (or BOTH parent/guardian's) signature Date

PLEASE ALSO REVIEW AND SIGN OTHER SIDE