WELL WITHIN NATURAL MEDICINE, INC.

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Acupuncture | Oriental Medicine | Energy Medicine | Energy Psychology | Nutrition

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

ADDENDUM FOR TREATMENT OF EPILEPSY OR CANCER

I have recently been diagnosed with epilepsy or cancer. I acknowledge that I am currently under the active care of a medical doctor for my condition. I am requesting to receive adjunctive care from Well Within Natural Medicine, Inc. that will be rendered in conjunction with the treatment program prescribed by my medical doctor.

Epilepsy: Yes or No Physician ______________________________

Cancer: Yes or No Physician ______________________________

Type of Cancer ______________________________

I am currently receiving chemotherapy: Yes or No Treatment Type ______________________________

I am currently receiving radiation: Yes or No Treatment Type ______________________________

I hereby request and consent to the use of Traditional Chinese Medicine techniques, including acupuncture, energy medicine, energy psychology and other associated modalities (nutritional supplementation, homeopathy, flower essences, herbal therapy, moxibustion, heat lamp, GuaSha, cupping, auricular, Tui Na, ESTIM) within the scope of practice of Oriental Medicine and massage therapy by Licensed Acupuncture Physician, Licensed Massage Therapist, and Eden Energy Medicine Advanced Practitioner Melanie A. Smith, of Well Within Natural Medicine, Inc. I understand that I have the right to refuse any or all treatments recommended to me by Well Within Natural Medicine, Inc. And in turn they have the right to refer me out for treatment or refuse me for treatment.

I am aware that the practice of oriental medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures, or examination.

By signing below, I show that I have read or have had read to me the above consent to treatment. I have been told about the potential risks, side effects, and benefits of acupuncture and other procedures and I have had ample opportunity to ask my questions. I understand the nature of the procedures, alternatives, risks, and probable outcomes. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment. I agree that I am ultimately personally responsible for my own health care. I knowingly, voluntarily, and intelligently consent to use the services offered by Well Within Natural Medicine, Inc.

I agree to release and indemnify Well Within Natural Medicine, Inc., Melanie A. Smith, AP, and her agents from and against any and all claims for which I (or my representative) may have for any loss, damage, or injury arising out of or in connection with my use of her services. This form is the sole and complete description of the professional relationship, is interpreted under Florida law and Florida will be the forum for any claims filed under or incident to this form. If any portion of this form is held invalid, the rest of the document will continue in full force and effect

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

______________________________ ______________________________
SIGNED DATE

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