BOUTIQUE
WELLNESS
MIND • SPIRIT • BODY

INFORMED CONSENT FOR CONSULTATION

I, _____, hereby authorize Boutique Wellness and Mary Ann Coffey to act as natural health consultants on my behalf. I understand that The Boutique Wellness and Mary Ann Coffey do not diagnose nor treat any condition or conditions. Mary Ann is licensed healthcare providers in the state of NC and that if I choose to follow through with any recommendations set forth by BW Mary Ann Coffey I should consult with my physician first. Furthermore, I understand the following:

Boutique Wellness NC does not offer diagnosis for any condition or conditions
BWNC does not offer treatment for any specific condition or conditions
BWNC does attempt to restore balance to the whole body by analyzing the negative environmental stimuli (food, movement, air, water, light, sleep, etc) that may be blocking the way to healing and optimal health. BWNC uses the following modalities to that end:

Therapeutic nutrition
Life Coaching
Homeopathy
Metabolic and Functional Profiling
Stretching and structural correction
Medication Therapeutic Management
Botanical Medicines
Genetic Testing

I recognize the potential risks and benefits of the procedures above and have had them all explained to me to my full satisfaction:

Potential risks: Allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by BWNC Mary Ann Coffey RPh CCN or of their affiliated personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health consultation provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my consultation record at any time and can request a copy of it by paying the appropriate fee. I understand that my consultation record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my consultation record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my consultant to the best of his/her ability.

_____
Date

_____
Signature of Client

_____
Signature of Client Representative or Guardian

Original to: Chart
Copy to: Client (if requested)