Holistic Child Psychiatry, LLC
Holistic Adult Psychiatry

Holistic Child Psychiatry, LLC
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INFORMED CONSENT FOR FREQUENCY SPECIFIC MICROCURRENT, PEMF AND/OR MICROCURRENT POINT STIMULATION

I am executing this informed consent document ("informed consent") to verify and confirm my discussion with Provider regarding the risks, benefits, and alternatives to treatment through Frequency Specific Microcurrent, PEMF and/or Microcurrent Point Stimulation.

I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time, including after treatment or services have begun. I understand that I may revoke this consent at any time before or during treatment.

I agree to bring to the attention of practice's clinical staff, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of clinical staff for further explanation until I have a full understanding before giving consent to this specific treatment or procedure.

FREQUENCY SPECIFIC MICROCURRENT, PEMF AND/OR MICROCURRENT POINT STIMULATION

Please advise your provider if you have any of the following conditions as they may be contraindications to treatment or require extra precautions:

1) Pregnancy - This is a CONTRAINDICATION for FSM treatment, as the treatment may alter certain chemicals in the body called prostaglandins that are important for pregnancy. If you think there is any possibility that you are pregnant, advise the practitioner and DO NOT undergo FSM treatment.
1) Any type of pump (ex. Insulin pump, pain pumps) –these must be turned off before being treated
2) Demand type pacemaker- The current used in FSM should not cause any problems, but to be sure, always check with the manufacturer of your type of pacemaker before treatment. If you have this type of pacemaker, the electrodes and towels used in FSM will need to be placed in certain locations of the body further from the pacemaker.
3) Cardiac monitor- If you are on a cardiac monitor (like a EKG or Holter monitor), be aware that FSM will interfere with the readings picked up by the monitor as well as the alarms.
4) Blood clots- Please advise your provider if you currently have a blood clot (deep vein thrombosis, pulmonary embolus, etc), as there are certain frequencies that should not be used. Al-

though no harm has ever been demonstrated with treatment, theoretically certain frequencies may affect the coagulation process.

RISKS

I understand that, as with any health treatment, Frequency Specific Microcurrent, PEMF and/or Microcurrent Point Stimulation is not without risk. Potential risks of this treatment include, but are not limited to:

[**Indemnification and Hold Harmless**: I agree to indemnify and hold IMWT and any of the staff, including the Doctors, Physician Assistants, Medical assistants, students, and volunteers HARM-LESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including court costs and attorney's fees brought about as a result of my FSM treatment. Initials_____

I acknowledge and understand that there are potential risks and hazards associated with FSM treatment, as previously noted above, and also potential symptoms such as a tingling sensation, skin irritation, or pain during or after treatment, as well as failure to improve or worsening of my condition. I understand, that while there are studies showing benefit with FSM treatments, FSM is not routinely used in standard medical treatment, and not considered standard of care

Initials _____

I understand that other side effects and risks may occur.

BENEFITS

I understand the thought process behind why Provider has suggested this particular treatment. I understand that, in general, Frequency Specific Microcurrent,PEMF and/or Microcurrent Point Stimulation may provide benefits that include relief, prevention, improvement or elimination of my presenting symptoms, though no particular outcome can be warrantied or guaranteed.

ALTERNATIVES

As alternatives, Provider encourages me to speak with and consider the advice of other providers, including conventional or mainstream physicians and providers. In addition to discussing other modes of therapy that may be used for the treatment of my condition, Provider and I have discussed, and I understand, the possibility of a referral to a specialist for my condition(s) if I have not already consulted with an appropriate specialist.

I also understand that one alternative to this treatment is to refuse this particular treatment and to seek alternative treatments with Provider or Practice, or to refuse this particular treatment without seeking alternatives with Provider, Practice, or any other providers.

NOTE: Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing this form. Do not sign this form if you have taken medications which may impair your mental abilities or if you feel rushed or under pressure.

By signing below, I acknowledge and certify that I have had opportunities to ask questions and have had them answered to my satisfaction; I have read and fully understand the foregoing Informed Consent, and I have all of the knowledge I currently desire; I have discussed the issues noted above with Provider; and I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

PATIENT

SIGNATURE: _____

PRINT NAME: _____

TITLE (if legal representative or guardian): _____

DATE: _____

I have explained this Informed Consent and answered all questions in layman's terms, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

PRACTICE

SIGNATURE: _____

PRINT NAME: _____

DATE: _____