WILDE INTEGRATION

wildeintegration.com | Dr. Sarah P. Wilde, GPC, AP

CLIENT INFORMED CONSENT + FINANCIAL RESPONSIBILITY DISCLAIMER

I have undergone a standard, conventional medical diagnostic workup and have been made aware of my diagnosis and/or health condition(s). If the diagnosis is cancer, I have consulted with an oncologist and I have been advised of the standard, recommended approach to treatment for my condition.

Of my own volition, I have made the decision to embark on a guided home nutritional metabolic therapy program to help detoxify my body, strengthen my immune system and improve my health condition. This nutritional approach includes either a complete or modified Gerson Therapy protocol. My spouse or significant other and/or immediate family members are aware of my choice. I am choosing to employ *Dr. Sarah P. Wilde, GPC, AP* to assist me in this process by educating, guiding and monitoring my progress through regularly scheduled follow-up consultations, review of lab testing results, imaging studies (if indicated), adjusting my therapy protocols and if or when necessary, recommending appropriate supportive nutritional therapies. I understand that, in some cases, it may be recommended that I pursue further conventional medical work ups or concurrent conventional medical treatments.

I have personally researched this nutritional program and have made my decision freely without coercion. I understand that this non-conventional alternative therapy may not have been investigated, reviewed and/or approved by the FDA or other health authorities, and that there may be no proven benefit over more traditional modalities. **I HAVE BEEN GIVEN NO GUARANTEES OR PROMISE OF SUCCESS, CURE OR REMISSION OF DISEASE PROCESS BY THE APPLICATION OF THIS NUTRITIONAL THERAPY (GERSON THERAPY OR A MODIFIED VERSION OF IT)**. ** Place your initials at each box below:*

*****_____ I understand that by making this decision, **I have assumed COMPLETE and TOTAL CONTROL and FULL RESPONSIBILITY for my decision regarding my choice of how to address my health condition and I WAIVE OR RELINQUISH *Dr. Sarah P. Wilde, GPC, AP* or any affiliated institution or involved parties from any claims, liabilities or legal actions whatsoever that may arise from the said recommendation and/or services or guidance rendered to me**.

*_____ I understand that *Dr. Sarah P. Wilde, GPC, AP* will maintain my privacy to the highest standards and **will not disclose my personal health information** or personal data to any requesting or attending party unless I have initially given approval in writing.

*_____ I understand that there is **no health insurance coverage** for the services or guidance provided and **I am fully responsible financially**, agreeing to meet my financial obligation **24-48 hours prior to the date of service** or appointment time or the service will otherwise be rescheduled for a later date

*_____ I acknowledge **all appointments are set in Eastern Standard Time** and **failure to attend** the appointment **will result in a charge of 50% of the service** as a no-show or late-cancelation fee **if notice is not given with need to reschedule 48 hours in advance**.

Client name (printed)_____

Client signature_____

Witness (person who has Power of Attorney)_____

Today's Date_____ Time_____

Note: Returning this completed form WITH SIGNATURE AND DATE will be construed as a legal document personally completed, reviewed and approved by the client.