



# DR. HILARY COSTELLO

HOLISTIC DERMATOLOGY \* NATUROPATHIC MEDICINE \* SKIN SURGERY

## PATIENT INFORMED CONSENT TO TREAT

This document is a binding agreement (the "Agreement") between Luca Holistic Medicine ("We", "Us", "Our") and the individual patient whose name and signature appears below ("You", "Your"). In consideration of the health care services which may be provided to You by Us at the present time and all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

**1) Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Us to provide You with health care treatment which, depending on Your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, minor surgery, gynecology, radio frequency procedures, intravenous micronutrient and botanical therapy and heavy metal chelation, (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You acknowledge that We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments.

(Initials) \_\_\_\_\_

**2) Experimental Nature of Treatment.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, including without limit intravenous micronutrient therapy, botanical medicine, homeopathic medicine, vitamin and nutrient therapies, dietary recommendations on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. We have informed You that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect.

(Initials) \_\_\_\_\_

**3) Minor Surgery, Injection therapy Risks, Side Effects, Complications.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation: swelling; increased pain; bleeding; dizziness, numbness; scarring; scar or keloid formation; asymmetry; allergic reaction; discoloration; soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments, all of which may be permanent. Treatment may very rarely cause infection; injury to nerves, temporary or permanent alteration in sensation; the need for additional surgery or hospitalization.

(Initials) \_\_\_\_\_

**4) Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines, and FDA approved prescriptive medicines, chelating agents, local anesthetic (procaine, Bupivacaine, Lidocaine), and local subcutaneous anesthetic infiltration (with or without epinephrine) which will be explained to you before injections.

(Initials) \_\_\_\_\_

**5) Medical Staff.** You are aware that among those who attend You on Our behalf are medical, nursing and other health care personnel employed by Us or in training, who unless requested otherwise, may participate in Your patient care

(Initials) \_\_\_\_\_

**6) Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reaction You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You agree to update Us periodically should this list change.

(Initials) \_\_\_\_\_

