HARMONY HEALTH GROUP LTD- Dr Amina Davison

TERMS AND CONDITIONS

The intention of this consent form is to help patients, clients, and authorised representatives become better informed so that they may give or withhold consent to undergo diagnosis and treatment after having an opportunity to discuss health concerns, including potential benefits and risks, and treatment alternatives.

The PATIENT, CLIENT, or AUTHORISED GUARDIAN or REPRESENTATIVE, (hereafter referred to as “patient or representative”) acknowledges the opportunity to read and inquire about this consent and all the items addressed herein and hereby authorise Dr Amina Davison and all affiliated clinical services (hereafter referred to as “clinician”), in accordance and within the scope and limits of their clinical licence(s), to perform or recommend any of the following procedures for diagnosis and/or treatment:

Common Diagnostic Procedures: venipuncture, radiography, laboratory, x-ray, ultrasound, etc.

Alternative Diagnostic Procedures: including diagnostic methods, functional laboratory testing, and devices that may fall outside of the “conventional standard of care.”

Lifestyle Counselling: therapeutic dietary advice and guidelines and the promotion of wellness including, but not limited to, recommendations for sleep, exercise, stress management and reduction, balancing of work and self-care activities, and developing and nurturing healthy relationships and community relationships.

Medical Nutrition: therapeutic nutrition, nutritional supplementation and intramuscular vitamin, mineral, amino acid, lipid, phytonutrient, and metabolite precursor and other nutrient injections, as permitted by licensure.

Botanical Medicine: medicinal herbs and plant derivatives prescribed as loose teas, alcohol or glycerine tinctures, capsules, tablets, creams, suppositories, etc.

Intravenous Therapies: including high dose vitamin, mineral, amino acid, lipid, botanical and other nutrients.

Lifestyle and Wellness Counselling: to promote improved lifestyle strategies and wellness, but not including the specific treatment of known or suspected mental illness.

Prescription Medications: As allowed by the clinician’s licensure and for both NICE-approved and non-NICE approved (i.e. “off label”) applications.

Hormonal Replacement: oral or transdermal hormonal applications intended to restore symptomatic patients to levels at or above age-appropriate hormone levels through bioidentical, synthetic, and animal derived preparations.

Group Counselling: to facilitate efficient and effective community creation and education regarding the diagnosis, treatment and management of health concerns.

Informed Consent:

The Patient or Representative acknowledges the right, opportunity and responsibility to ask questions and to become informed regarding the clinician’s diagnostic and treatment recommendations to his or her satisfaction. Patient acknowledges that all questions asked have been fully answered by the clinician.

Potential Risks:

The Patient or Representative acknowledges and accepts that there are risks to the diagnosis and treatment measures that fall within and outside the conventional standard of care, and that these risks may include: unintended exacerbation of symptoms, new symptoms, allergic and other unintended injury and side effects from exercise, lifestyle modifications, dietary modifications, herbal and nutritional supplements, injected or intravenous therapies, hormonal therapies, adverse interactions with drugs, herbs and/or nutrients. The specific risks associated with the proposed procedures have been explained to the patient and/or the patient’s representative.

No Guarantee of Potential Benefits:

The Patient or Representative acknowledges that treatment may result in the restoration of health and optimal functional capacity, relief of pain and symptoms, injury and disease recovery, and prevention or reversal of disease or disease progression, but ALSO acknowledges that no expressed or implied guarantees or representations can or have been made by the clinician or any affiliated staff regarding the cure or improvement of the patient’s condition.

Limitations of Full Disclosure:

The Patient or Representative acknowledges that the clinician cannot know or anticipate and explain every possible risk or complication, and that the patient or representative willingly chooses to rely on the clinician to exercise their best judgment within the bounds of their licensure for any of the above.

Responsibility to Report Possible Pregnancy:

The Patient or Representative agrees to alert the clinician should she suspect that she is or may be pregnant in acknowledgement that some of the diagnostic or therapeutic techniques could present risks to a pregnancy.

Disclosure Coverage:

The Patient or Representative acknowledges and agrees that consent form will cover the entire course of treatment for the present condition and for any future condition(s) for which treatment is sought.

Willing Participation:

The Patient or Representative understands that the patient is free to discontinue participation in any and all aspects of the medical care provided by the clinician at any time, and that the patient or representative is responsible for informing the clinician of the adherence to or discontinuation of any and all aspects of care and that the choice to discontinue treatments may create the risk of adverse effects for which the patient or representative bears full and sole responsibility.

Clinician Collaboration:

The Patient or Representative understand that the clinician may consult with preceptors, clinical student residents and colleagues related to the care provided, and that the patient or the patient’s authorized representative have the right to decline their presence or involvement during any aspect of the patient’s care.

Agreement to be Contacted:

The Patient or Representative understands and accepts that the clinician or affiliated staff may contact the patient or representative (e.g. by phone, email, voicemail, SMS text message) to consult or exchange information related to the patient’s care.

Remote Consultations:

The Patient or Representative acknowledges that at times, consultation may be provided remotely and without direct contact with a clinician. In such cases, the patient or their representative agree to maintain direct contact with a licensed health care provider that is appropriate for the patient’s age, gender and known or suspected health conditions.

Medical Record Keeping and Privacy:

The Patient or Representative understands that records of the health services provided will be kept for a minimum of three, but no more than ten years after the date of the last visit or consultation. The patient or representative also acknowledges that information within the record may be analysed for research purposes, and that in such case, the patient’s identity (name, address, exact birthdate) will be kept confidential. Otherwise, this record will be kept securely and confidentially and without release to others unless so directed by the patient or representative, or as may be required by law or as necessary for insurance claim or other payment processing.

Patient’s Responsibility to Disclose Information:

The Patient or Representative understands that the patient bears full responsibility for any adverse effects experienced during or after the course of treatment that were reasonably deemed to be caused or related to a deficit in the full, accurate and timely disclosure of symptoms and other medical information to the clinician to the best of the patient’s or representative’s ability.

Responsibility for Payment:

The Patient or Representative understands that some or all of the recommended diagnostic and treatment measures may fall outside the conventional standard of care and may not be approved or covered by the patient’s insurance because the services rendered fall outside the “standard of care,” and in such an event, that the patient accepts full responsibility for all associated costs and fees.

Dispute Resolution:

The Patient or Representative agrees that short of overt negligence or malpractice, that any complaint or dispute that arises related to the diagnosis or treatment from clinician will be settled through binding mediation in the state which the clinician is licensed.

Cancellation Policy:

For all consultations, a £50 deposit will be taken at the time of booking and the balance will be due no later than 2 days before the scheduled appointment. Non-payment of the remaining balance at the time due may result in the appointment being cancelled without refund of the deposit.

For any cancelations made 48 hours or more before the scheduled appointment: Full refund will be given.

Less than 48 hours and up to 1 hour before scheduled appointment: Partial refund, minus £50 deposit.

Less than 1 hour before appointment or no-show: No refund. (Exceptional circumstances may receive a partial refund at the discretion of the clinic).