Consent to Care and Financial Agreement

CONSENT TO PROVIDE CARE

I wish to receive consultative services from holistic clinical pharmacist, Cathy Rosenbaum, PharmD MBA RPh CHC CDP CFNC. I give my consent to care and authorize her to recommend dietary supplements including herbal products, vitamins, other nutraceuticals, lifestyle tips via her eight balance point model for health, and/or questions for my primary care physician, as are in her judgment able to enhance my well-being. I understand the following statement regarding my use of dietary supplements and manufacturers' labeled product claims: **"DISCLAIMER: These statements have not been evaluated by the Food and Drug Administration. Products mentioned are not intended to diagnose, treat, cure or prevent any disease. Information and statements made are for educational purposes and are not intended to replace the advice of your health care professional."** I understand the practice of holistic medicine, including referrals to qualified non-traditional medicine practitioners, is not an exact science, and acknowledge that no guarantees are being made to me as a result of my evaluation and/or referrals by Dr. Rosenbaum.

Client Signature Witness Date

AUTHORIZATION TO RELEASE INFORMATION

I understand that records concerning my condition and care may be kept on file for seven years after my office visit. I agree that all medical or other information about me which has been acquired in the past by Dr. Rosenbaum and any information relating to this care may be released or disclosed, from time to time, to any physicians, other healthcare professionals, or non-traditional medicine practitioners caring for me.

I (as a client or agent of the client) hereby authorize Dr. Rosenbaum to permit access to and/or release medical information, including copies of such information, to any physicians, other healthcare professionals, or non-traditional medicine practitioners caring for me. I understand that it is the standard practice of Dr. Rosenbaum to communicate with my primary care physician, specialty care physicians, or non-traditional medicine practitioners only with my written permission.

Client Signature Date

FINANCIAL AGREEMENT

I understand that payment for the services to be rendered by Dr. Rosenbaum is my responsibility and I agree to pay all charges at the time of the service by way of personal check or money order. Credit cards are not accepted. I understand that Dr. Rosenbaum's services are not covered in full by third party payers or Medicare. I further understand that Dr. Rosenbaum does not receive reimbursement from Medicare/Medicaid and that I am responsible for all charges at the time of service.

Client Signature Date

Effective February 1, 2005
Last Revision June 2, 2020