

## Consent for Treatment and Statement of Understanding for Adults

1. I desire evaluation and/or treatment for my symptoms and medical issues.
2. I desire to have further investigation into the possible biological problems which either coexist with or contribute to the above mentioned problems.
3. I agree to the use of blood, urine and/or fecal specimens for study by various laboratories selected by the doctors in consultation with me.
4. I have been informed that none of the practitioners with Creation's Own are providers for any insurance company. I understand that I am responsible for payment for all services, and that payment is due when services are rendered. I have had an opportunity to review the fee(s) prior to consultation and/or procedures.
5. I understand that I am responsible for filing my own insurance claims, and that my insurance company may not provide coverage for consultations, diagnostic testing, or other procedures or treatments.
6. I understand that no promise or guarantee of outcome or offer of cure is made by any process, procedure or medical treatment offered by the doctors mentioned.
7. I have had an opportunity to read and have been provided published medical research and/or research protocols, which concern the care and treatment being provided.
8. I consent to the use of data derived from my testing or treatment, apart from my name, in the eventual publication of outcomes of this treatment or care.
9. I agree to let the doctors consult with or share the data concerning my medical issues with other physicians, professors, and any other affiliation that the doctors deem relevant.
10. **Under Florida law**, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law

Florida Statute 458.320

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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