The Roots of Healing
Karen Davis, LCSW
New Patient Forms

Agreement to receive homeopathic consultation

I _____ (print name) have read and understand the office policies of Karen Davis, LCSW and The Roots of Healing as described below:

- After the initial appointment, I understand that I need to make regular follow-up appointments (every four to six weeks), and that I can make brief calls between these appointments if I have questions.
- I understand that fees will not be reimbursed by any insurance for homeopathy, and that I am responsible for paying for services at the time of the appointment.

By signing this form, I certify that I agree to the terms above.

Client's signature: _____ Date: _____
(Guardian's signature if client is under 18 years old)

Consent to Receive a Homeopathic Consultation:

I give permission to Karen Davis to give homeopathic consultation to me or my child. I have been informed and understand that Karen Davis is not a medical doctor and does not prescribe any medication or give diagnostic testing, and that I am seeking alternative treatment in the form of lifestyle, educational, and homeopathic advice and/or recommendations.

Under no circumstances should any suggestions be taken as a diagnosis or direction against a licensed physician. I am to continue to have a primary physician/pediatrician for me or my child and to continue any medication that has been prescribed by a physician for myself or my child. I accept full responsibility for any actions taken by myself and/or my child concerning any homeopathic consultation with Karen Davis. I hereby release Karen Davis and The Roots of Healing, from any liability for any possible damages or loss during our association.

In the event of an emergency concerning me or my child, I am to call 911 immediately, go to an emergency care center and/or contact our physician.

Client's name: _____

Client's signature: _____ Date: _____
(Guardian's signature if client is under 18 years old)