INFORMED CONSENT (TEXAS ONLY)

NOTICE: This Informed Consent is intended **exclusively for use by Texas-licensed providers** and incorporates the requirements of **22 Texas Administrative Code §171.2(b)** governing Complementary and Alternative Medicine (CAM). Execution of this document constitutes the patient's informed consent for both general care and CAM treatment, and **no separate CAM addendum is required**.

[NAME OF PATIENT] (hereinafter "I") seek the medical services of Holistic Integrative Health. I am executing this informed consent document ("Informed Consent") to verify and confirm my discussion with John Gonzalez, DNP, APRN, ACNP-BC, ANP-C regarding the **nature, risks, benefits, objectives, alternatives, and regulatory status** of the treatments offered, including complementary and alternative medicine ("CAM").

I understand that I am an active participant in the decision-making process, that I am free to decline services or treatments at any time, and that I may withdraw my consent at any time. I agree to notify Practice's clinical staff if I do not understand any aspect of the proposed treatment so that additional explanation may be provided prior to my consent.

This Informed Consent must be completed **prior to initiation of treatment** and will be maintained as part of my medical record.

1. CONDITIONS / DIAGNOSES

The condition(s) or diagnosis(es) for which treatment is being offered include (list all):

2. TREATMENTS OFFERED (INCLUDING CAM)

The treatments being offered for the above condition(s) or diagnosis(es) include conventional, complementary, alternative, functional, naturopathic, or integrative medicine modalities ("Functional Medicine" or "CAM"), which may include nutritional therapy, lifestyle modification, supplements, off-label medication use, and other non-conventional approaches.

Each CAM treatment has been explained to me and linked to a specific condition or diagnosis.

3. ASSESSMENT (**Initial each line or write "N/A" if not applicable**)

_____ Conventional methods of diagnosis and non-conventional diagnostic approaches have been explained to me.

_____ An appropriate medical history and physician examination have been completed.

_____ Conventional medical treatment options have been discussed, including referrals when appropriate.

_____ Prior conventional treatments and outcomes have been reviewed, including whether I have declined conventional options.

_____ An assessment has been completed regarding whether the proposed CAM therapies could interfere with other recommended or ongoing treatments.

4. OBJECTIVES, BENEFITS, AND MECHANISM OF ACTION

I understand the objectives and expected outcomes of the proposed treatment(s), which may include functional improvement, symptom relief, preventive benefit, or psychosocial improvement. I understand that no outcome can be guaranteed.

I have been provided a plain-language explanation of the **therapeutic basis or mechanism of action** for each CAM treatment proposed.

5. RISKS AND RISK–BENEFIT COMPARISON

I understand that, as with any health treatment, Functional Medicine and CAM treatments are not without risk. Potential risks include, but are not limited to, allergic reactions, sensitivities, adverse effects from supplements or medications, interactions with other treatments, failure to improve, or worsening of my condition.

I understand that the **risks and benefits** of the proposed treatments have been discussed, including how they compare favorably or unfavorably to other available treatments for the same condition, as well as compared to receiving no treatment.

6. FDA AND REGULATORY STATUS

If applicable, I understand that substances or devices used in my treatment may be:

_____ Approved for human use by the U.S. Food and Drug Administration (FDA);

_____ Dietary supplements exempt from FDA preapproval under the Dietary Supplement Health and Education Act (DSHEA);

_____ Pharmaceutical compounds not commercially available and subject to clinical investigation standards.

I understand that some medications or devices may be used **off-label**, meaning in a manner not specifically approved by the FDA, and that this practice has been explained to me.

7. ALTERNATIVES AND COORDINATION OF CARE

I understand that alternatives to the proposed treatments include conventional or mainstream medical care, referral to specialists, or refusal of treatment. I understand that Provider does not replace my primary care physician and that I am responsible for maintaining a relationship with a primary care provider for routine, urgent, and emergency care.

8. INDIVIDUALIZED TREATMENT PLAN AND ONGOING REVIEW

I understand that my treatment plan is individualized based on my medical history, examination, and prior records, and may include further testing, referrals, or additional modalities.

I understand that my treatment will be **periodically reviewed at reasonable intervals** to assess progress, response, and any new information relevant to my condition.

9. PATIENT RESPONSIBILITIES

I agree to disclose all medications, supplements, allergies, medical conditions, and care received elsewhere. I agree to notify Practice immediately of any adverse effects, pregnancy, or breastfeeding status.

FINANCIAL AND INSURANCE DISCLOSURE

I understand that Practice does not accept insurance and that I am financially responsible for services rendered. I understand that CAM and Functional Medicine services may not be covered by insurance or government payors.

PATIENT CONSENT

By signing below, I acknowledge that: - I have read and understand this Informed Consent; - All required disclosures under Texas law have been made; - I have had the opportunity to ask questions and received satisfactory answers; - I understand the risks, benefits, objectives, alternatives, and regulatory status of the treatments offered; - I voluntarily consent to receive the treatments described above.

Patient Signature: _____

Printed Name: _____

Date: _____

PROVIDER ATTESTATION

I certify and attest that: - I am duly licensed to practice medicine or provide healthcare services in the State of Texas; - I have conducted an appropriate medical history and examination consistent with my licensure, scope of practice, and applicable standards of care; - I have determined, in the exercise of my professional medical judgment, that the CAM treatment(s) described above have a **reasonable potential for therapeutic gain** for this patient; - The treatment plan is **individualized**, based on the patient's condition(s), medical history, prior treatments, and clinical findings; - I have discussed conventional medical options, including referral to other providers when appropriate; - I have assessed and considered potential interactions or interference between CAM treatment(s) and other recommended or ongoing care; - I have explained the objectives, expected outcomes, risks, benefits, alternatives, and regulatory status of the proposed treatment(s) in a manner understandable to the patient; - I will periodically re-evaluate the patient's response to treatment and modify or discontinue treatment as clinically indicated; and - This Informed Consent complies with **22 Texas Administrative Code §171.2(b)** and is maintained as part of the patient's medical record.

I believe the patient has been adequately informed, has demonstrated understanding, and has voluntarily consented to the treatment.

Provider Signature: _____

Printed Name & Credentials: _____

Texas License Number: _____

Date: _____