Dr. Kevin Davison N.D., L.Ac
Patient Conditions of Treatment and Informed Conset to Treat

This document is a binding agreement (the "Agreement") between Dr. Kevin Davison N.D., L.Ac ("We" "Us" "Our") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the heath care services which may be provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Us to provide You with heath care treatment which, depending on Your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, Minor Surgery, Acupuncture, Prolotherapy and/or Platelet Rich Plasma injections, Intravenous Micronutrient and Botanical Therapy and Heavy Metal Chelation, (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You acknowledge that We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments. **(Initials)** _________

2. **Experimental Nature of Treatment.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, including without limit Acupuncture, Intravenous Micronutrient Therapy, Prolotherapy and Platelet Rich Plasma therapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. We have informed You that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect. **(Initials)** _________

3. **Risks, Side Effects, Complications.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling; increased pain; bleeding; dizziness, numbness; scarring; scar or keloid formation; asymmetry; allergic reaction; discoloration; soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments;, all of which may be permanent. Treatment may very rarely cause infection; injury to nerves, temporary or permanent alteration in sensation; the need for additional surgery or hospitalization; spinal cord injuries, Pneumothorax (temporary lung collapse), paralysis, or other serious or debilitating injuries or death. **(Initials)** _______

4. **Description of Treatments**. The exact procedure, solution used and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines, and FDA approved prescriptive medicines, chelating agents, local anesthetic (Procaine, Bupivacain, Lidocaine), concentrated sugar water or dextrose, concentrates or your own blood (Platelet Rich Plasma) and, on occasion, other substances and local subcutaneous anesthetic infiltration (with or without epinephrine) which will be explained to you before injection. **(Initials)** _______

5. **Medical Staff.** You are aware that among those who attend You on Our behalf are medical, nursing and other health care personnel employed by US or in training, who unless requested otherwise, may participate in Your patient care. **(Initials)** _________

6. **Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You agree to update Us periodically should this list change. **(Initials)** _________

7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that You have, You are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. **(Initials)** _________

8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. **(Initials)** _________

9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of Hawaii without regard to any choice of law principal. Any dispute between You and Us shall be adjudicated in state or federal court in Maui County, Hawaii and You submit to the jurisdiction of any such court. **(Initials)** ________

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient		**Legal Guardian/Proxy/Representative**	
Signature	Date	Signature	Date
Print Patient Name		Print Name of person signing	

Physician Certification: I hereby certify that one of my associates or I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Physician *Date*