H E A L I N G
T H E
E Y E
& Wellness Center
Dr. Edward C. Kondrot, MD (H), CCH, DHt.
2001 W Camelback Rd Suite 255
Phoenix, Arizona 85015

TREATMENT CONSENT

I authorize the performance upon ____
(Myself/Name of Patient) an alternative medicine evaluation which consists of nutritional and vitamin therapy. I may or may not be a candidate for the listed therapies and I am seeking the advice of Dr. Edward C. Kondrot, MD, (H), CCH, DHt.

These have not been proven to be effective through scientific research. While trying these approaches, I will remain under the care of my medical doctor and will have my health/vision checked periodically. He or she may recommend other treatments, some that may not be available at the time of consent. If this is the case, I will evaluate these options.

I understand the nature and risk of alternative therapies and the possible complications. I will be pursuing alternative therapies as a compliment to my regular medical program and I will not discontinue any medication/treatment without conferring with my existing doctor.

I also consent to the photographing and video taping of this interview to be used for medical, scientific, or educational purposes, provided my identity is not revealed.

I also understand that insurance will not pay for these services and that I will be responsible for payment in full at the time of service.

I also understand that no guarantee or assurance has been given by anyone as to the result that may be obtained.

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Patient or Guardian Witness