CHYENNE GIARNESE APRN INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Chyenne Giarnese APRN via Jennifer Stagg ND LLC, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures (e.g. physical exams, history review, venipuncture, Pap smears, interpret laboratory tests), minor office procedures (e.g. dressing a wound, ear irrigation, injections), medicinal use of nutrition (therapeutic nutrition, nutritional supplementation), botanical medicine (botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories), traditional medications (including but not limited to antibiotics, contraceptives, hormonal support), Controlled medications (including but not limited to stimulants, medical cannabis, & testosterone therapies), homeopathic remedies (the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses), experimental medications (oral & injectable peptides, vitamin supplementation) lifestyle counseling and hygiene (diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities), psychological counseling, physical medicine (electrotherapies, electromagnetic, hydrotherapies), Medical cannabis (evaluation for qualifying condition, endocannabinoid system consulting)

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from venipuncture or procedures, aggravation of pre-existing symptoms, discomfort, pain, bruising, burns, and lightheadedness. Individual risks associated with medications prescribed will be discussed in detail at time of consultation.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to all pregnant women: all female patients must alert the doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy.

In compliance with all federal laws, Chyenne Giarnese APRN, Mark S. Stagg DC LLC, Jennifer J. Stagg ND LLC, and Whole Health Associates LLC must inform you that there are other options pertaining to your healthcare services. Specifically, it should be noted that you have presented to the Whole Health Wellness Center voluntarily for your medical needs. As part of the evaluation of your condition and any required treatment, your provider may determine that chiropractic care, acupuncture, naturopathic care including but not limited to supplementation, dietary counseling, medication management, psychotherapy, biofeedback, and laboratory testing may be needed. Chyenne Giarnese, APRN, Mark S. Stagg DC LLC, Jennifer J. Stagg ND LLC, and Whole Health Associates LLC offer many of these services on-site as a convenience to our patients. By signing this form, you acknowledge that you are aware you can seek medical care at an unaffiliated practice, including consulting your primary care physician.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Chyenne Giarnese APRN, Mark S. Stagg DC LLC, Jennifer J. Stagg ND LLC, and Whole Health Associates LLC or any of her personnel regarding cure or improvement of my condition. I

understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Chyenne Giarnese APRN, Mark S. Stagg DC LLC, Jennifer J. Stagg ND LLC, and Whole Health Associates LLC will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying an appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my physician to the best of her ability.

_____	_____
Date	Name of Patient
_____	_____
Signature of Patient	Signature of Patient Representative or Guardian