Medical Treatment Consent for Alternative Therapies

Date: **[Insert Date]**

Patient Name: **[Insert Patient Name]**

Patient Address: **[Insert Patient Address]**

To Whom It May Concern,

I, **[Insert Patient Name]**, born on **[Insert Date of Birth]**, hereby give my consent for medical treatment involving alternative therapies as discussed with my healthcare provider.

I understand that alternative therapies may include but are not limited to:

- Acupuncture
- Herbal Medicine
- Chiropractic Care
- Homeopathy
- Massage Therapy
- Nutritional Counseling

I acknowledge that I have discussed the potential risks and benefits of these therapies with my healthcare provider and have had the opportunity to ask questions. I understand that results may vary and that my provider cannot guarantee specific outcomes.

Furthermore, I have disclosed my complete medical history and current medications to ensure the safety and efficacy of the proposed treatments.

This consent is valid until **[Insert Expiration Date]** or until revoked in writing.

By signing below, I confirm that I understand the information presented to me and willingly consent to the alternative therapies.

Patient Signature: _____

Date: _____

Healthcare Provider Signature: _____

Date: _____